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OTHER TOPICS

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Editorials

ESTABLISHED IN 1872

"You and Your Hospitals"

THE United Hospital Fund has issued a most useful digest of the 2,000-paged Hospital Survey of New York which should be widely read, since it gives one an opportunity quickly to familiarize oneself with today's hospital problems and tomorrow's needs on a comprehensive community scale. It is written and illustrated in popular style and is directly addressed to the intelligent citizen who, of course, may some day be ill and may be assumed to take an interest in such a personal possibility. But the graphic data supplied will well repay anyone's perusal, be he layman or doctor. It is the hospital system, not just the hospital, that one is made to see—the hospitals of the metropolis, not the hospital of a parish.

Doctor Santa Claus

A PRESS release from the Works Progress Administration, New York City, under date of August 2, remarks as follows:

> *One of the clinic supervisors, a dentist, is responsible for the statement that patients in free clinics are more difficult to satisfy than private patients. He cites the instance of one of his private patients who was later forced to attend a free clinic. Once she was sure of not having to pay for the work, she wanted two sets of teeth made for her, the extra one to be used as a spare—for special occasions, or in case of accident.*

Governmental trends are more and more in the direction of coddling and catering, and in the field of medicine they may yet reach formidable limits. The beneficiary senses this. The consideration is votes, giving a balance of power in elections. Thus a baneful phenomenon comes into our political system. The isolated instance given in the foregoing press release provides just a hint of what the future set-up will be like on a vast scale.

Health and Economics

THE following passage from an editorial in the August issue of *Hospital Progress*, official organ of the Catholic Hospital Association, seems to us to express admirably and adequately what came into the minds of many of us as a result of the proceedings of the National Health Conference which was held in Washington July 18, 19, 20, 1938, at which time the National Health Program was submitted to the conferees as a part of the Social Security Program:

> *To revolutionise a nation's procedure with reference to a matter as deeply personal as medical care, on a basis of mingled certainties and uncertainties, possibilities and probabilities, would be justified if a national emergency of overwhelming magnitude demanded temerarious action. It remains for the American people to determine whether such a national emergency exists with reference to health care. To reach a conclusion upon the point the people will follow leaders upon whose consciences will rest an enormous responsibility. Only the utmost sincerity and an unselfish concern for the public welfare can justify the assumption of such a huge responsibility.*

The Need of a National Council on Medical Education, Licensure, and Hospitals

DEAN WILLARD C. RAPPLEYE, of the Faculty of Medicine, Columbia University, thinks that the time has come to set up a National Council on Medical Education, Licensure and Hospitals from within our present organizations, made up of representatives of the universities, medical schools, hospitals, practicing profession, specialty boards, state licensing bodies and public health agencies. The problems from college preparation to retirement from professional life should be looked upon as parts of a single educational program. There are numerous problems, Dr. Rappleye points out, relating to general and medical education, pressing for study and solution, yet there is no convenient mechanism in existence by which these mutual problems of medical schools and colleges can be discussed and defined. The prospective student stands confused, and wide differences characterize the character and scope of the schools' curricula.

Dr. Rappleye concluded his recent address before the American Surgical Association in the following words:

> *The functions of the proposed National Council on Medical Education, Licensure and Hospitals would be those of studying the major educational needs of American medicine, of mobilizing the best current opinions regarding the different phases of professional training at its several levels, of formulating adequate standards for these activities, and of advising regulatory bodies and governmental agencies on standards, methods, procedures and areas of action. The National Council should, among other things, delegate to existing organizations all administrative functions and endeavor to coordinate the efforts and simplify the procedures of the multiple agencies now in operation. A central clearing house, carrying influence and prestige by virtue of the knowledge and judgment of its personnel, and providing a suitable vehicle of our own creation for cooperation on matters dealing with all features of medical education, transcending the activities and interests of any single group or organization, would be of the greatest practical value to the profession, the universities, the hospitals, the licensing bodies and the future health program of the entire country.*

Problem Children at the Helm of State

AMERICAN political and economic scenes are dominated by passion. Graham Hutton, an Englishman, recently made an attempt in the *Atlantic Monthly* to fathom the reasons why this emotionalism keeps "the disarrayed Republicans and the discomfited Democrats, the embittered businessmen and the unenviable administration" from joining forces in a national effort of cooperative reconstruction. The Englishman is bewildered because all the parties concerned "are supposed to be united by a common desire to preserve capitalism and democracy." He considers this situation extremely dangerous.

But it seems to us that the same infantile emotionalism dominates the political and economic relationships of the Old World.

We suspect that the degree of emotionalism of the middle and lowly classes everywhere is determined largely by their deprivation of privileges. In so far as they find themselves enslaved by the system in vogue, and unable to engage in the exhibitionism and display that once enabled them, as they thought, to keep "ahead" of other folk, as well as unable even to escape the "internment" imposed upon them in their drudging environments, in just so far do they indulge in excitement as a safety-valve unforbidden by authority because meaningless, infantile and impotent. The more emotional an adult, the more he proves himself thwarted in respect to the desirable objectives of life. Thus he betrays himself as the inferior victim of the social Juggernaut which he really is. As lynching in the South has been ascribed to the dullness of life in many communities, so emotionalism in the political and economic spheres flares up as a kind of ignoble mode of asserting individualism of a kind.

The trouble with world statesmen is due to different factors—notably the thwarting of their power aspirations as they seek to compensate for their inferiorities.

It has been wisely suggested that psychiatrists should supplement diplomats—or supplant them—in intergovernmental dealings with statesmen, for these statesmen seem to be "nothing more than 'problem children' grown to adult life."

"The Doctor's View of War"

A GROUP of about thirty British physicians has published a book

("The Doctor's View of War") which discusses what the profession's attitude should be toward the mass murder in which, paradoxically, we are pacific partners.

The most optimistic view, this group thinks, is "that modern war will wreck the structure of society without inflicting any permanent biologic damage." Immediate effects are dysgenic. Something to think about is the British writers' point that the hybridization brought about by war offers a biologic advantage, making possible "new and more and more favorable combinations of characteristics." This, of course, does not offset the destructiveness of war. It does show that hate propaganda is a benighted technic.

The group cites disregard of the Red Cross and the bombing of cities as suggesting that we may be "on the verge of another age of barbarism."

What to do? Some great medical association, the group says, will have to call a conference of all the medical societies in the world which will put the medical profession on record as favoring the establishment of a system of collective security, such as a strengthened League mechanism might provide.

This is the group's formal judgment, but it lets slip in the book another thought which is informal and intriguing and which we like much more. This is a hint that our international profession, if forcefully coordinated, "could of its own initiative put a stop to war or at least so hamper the most bellicose government as to give it pause."

Not so fantastic, say we. Are we not all sick enough of infantile and brutal war mongering by now to begin to resist its menace effectively?

Substitutes for Transfusion

H. A. DAVIS and C. S. White [*Proc. Soc. Exper. Biol. and Med.* 38:462 (May) 1938] report the use of ascitic fluid as a serviceable substitute for whole blood in the transfusion of dogs, and suggest its use in man. Ascitic fluid is sterile and can be stored cold for months without change, no preservative additions being necessary. The *Journal of the American Medical Association* [3:14 (Oct. 1) 1938] suggests that the ascitic fluid be dried by evaporation and redissolved before transfusion. It lists as other transfusion substitutes gum-saline and gelatin-saline solutions, hemoglobin Ringer solution, placental and umbilical plasma, and the cadaver product first used by the Russians, but says nothing about the possibilities of dried and powdered blood.

Some years ago the MEDICAL TIMES [62:124 (April) 1934] suggested that it might be feasible to dry and powder citrated blood after the manner of milk and store it in cans or bottles. Dried blood, it would seem, should be superior to ascitic fluid from every standpoint except living cell content, in which they would be on a parity. Certainly it should be superior to dextrose in the field of nutritional therapy. Possible reaction factors would have to be studied. Dried and powdered blood would make direct syringe transfusion available to every practitioner and consequently greatly extend the field of modified transfusion. Until shown to be impracticable, use of such logical material should be our primary objective in seeking a substitute for ordinary blood, rather than recourse to the other substances cited, all points to be duly checked by animal experimentation.

We have tried to make our thought objective by means of the accompanying illustration of canned blood as the market will yet, presumably, know it.

It is an odd circumstance that we should play around with every substitute for blood except blood itself in the form suggested.

Associated Physicians
OF LONG ISLAND

SCIENTIFIC PROCEEDINGS

LONGITUDINAL Cerebral Sinus THROMBOSIS

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CIVILIZED man is enjoying better health every year, due to progress in the science of medicine. There seem to be some new diseases noted and found to be increasing in incidence. A recent example is epidemic diarrhea of the newborn, which has been a great source of trouble in metropolitan hospitals. Epidemic encephalitis, while not entirely new, has become generally known to the medical profession only since the pandemic of 1916 and 1917. The disease is increasing in prevalence in the United States.

Thrombosis of the large sinuses of the brain is increasing in incidence, or at least the diagnosis is being made more frequently. When thrombosis occurs, an area of brain is deprived of its normal venous drainage and symptoms follow which bear similarity to those of encephalitis. This case report of thrombosis of the superior longitudinal sinus illustrates the usual confusion in diagnosis and the difficulties in treatment as a pediatric problem.

Case Report:

A large, healthy, ten-months-old baby boy had sudden convulsions in a department store in Garden City lasting but a few minutes. Examination by a local physician showed no cause for the convulsions and the child returned home to Great Neck. He spent a restless afternoon and was examined by a pediatrician who could discover no evidence of disease, yet one and a half hours later the baby had severe convulsions which lasted nine days and terminated in death. Mustard baths and morphine only plunged the baby into deeper coma. He was rushed to Nassau Hospital, where examination showed him to have clenched fists, stiff spastic limbs and neck, edema of the retina, very mild redness of the throat, coarse tracheal râles, positive Kernig and Babinski and no abdominal reflexes. These physical signs could have been produced by increased intracranial pressure, so spinal puncture was done immediately, showing fluid under increased pressure, with 6 red blood cells and 6 polys per cubic mm. The course in the hospital was discouraging, for he never came completely out of coma and had to be supported entirely on intravenous glucose and clyses, oxygen inhalation, daily spinal punctures to relieve pressure, and chloral hydrate by rectum

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in an attempt to lessen the convulsions. By the third day, he was deaf and blind, his legs were spastically paralyzed, and his body began to swell with edema. On the fifth day his kidneys ceased to function and were goaded to action only by intravenous glucose. On the sixth day the liver was enlarged and from that time until his death on the ninth day he was virtually in a state of suspended animation. Treatment was withdrawn (that is, oxygen, glucose feedings, etc.) at the request of the father, who felt that the agony of going on living deaf, dumb, blind and paralyzed was too severe for the baby. It was amazing to see this baby living without sustenance of any kind, scarcely breathing at all, but never cyanotic; this was literally "sleeping sickness." Such a state of suspended animation must be akin to the hibernation of some animals with no stimuli coming to the nervous system and no impulses going out.

THE diagnosis upon which we worked throughout this illness was encephalitis and we assumed it was a virus disease. Daily spinal punctures showed:

1st day	6	red blood cells		6	polys	0 lymphos.
2nd day	330	"	"	2	"	2 "
3rd day	800	"	"	1	"	15 "
6th day	?			0	"	35 "

There was, as you see, never any pus in the spinal fluid, and we felt sure that we were not dealing with meningitis. The daily increase in red blood cells was thought at first to be an unfortunate contamination from the needle punctures, but autopsy showed that the red blood cells were from another source and were a part of the disease. Upon postmortem examination, we found an utterly hopeless amount of brain damage due to phlebitis and thrombosis of the superior longitudinal sinus of the brain. Although cultures of the spinal fluid had been sterile, yet the thrombus and adjacent parts of the brain contained *Streptococcus hemolyticus.*

Postmortem examination of the brain showed thickened blood vessels filled with coagulum from the parietal region backward. On the left surface of the brain was one small area of gray purulent matter. Section of the superior longitudinal sinus showed a firm thrombus filling the lumen and extending into the smaller branches. Sections of the brain showed softening adjacent to the thrombus and in the stem and cerebellum, with hemorrhagic foci in the blood vessels. Microscopic examination showed the markings obliterated from sections in an extensive zone in the mid-parietal region near the midline. There was intense inflammatory infiltration of the walls of the blood vessels. An antemortem thrombus in the sinus was adherent to the intima, which was replaced in many portions by fibrin, platelets and leukocytes. Bacteriologic examination showed cultures of *Streptococcus hemolyticus* from the sinus thrombus and adjacent brain cortex.

CEREBRAL thrombosis has a sudden onset of restlessness and convulsions. The spinal fluid pressure and cell count can be either normal or increased and culture is often sterile. Spinal fluid sugar is low and chlorides high and protein normal. There is usually absence of any evident infection during the illness. The prognosis is usually fatal, but some thrombi apparently undergo absorption, and when this happens the result is not a happy one, for acquired cerebral defects remain. This explains some of the cases of acquired neurologic abnormalities which are wrongly ascribed to an early and non-fatal case of encephalitis.

Summary:

This case report of superior longitudinal thrombosis points out (1) the increasing prevalence of the disease, (2) the similarity with encephalitis, (3) the apparent absence of evident infection during the illness, (4) and the overwhelming brain damage seen at autopsy.

PROFESSIONAL BUILDING.

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REMARKS ON THE *Conduct of Labor*

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BECAUSE of limited time these remarks will be confined to "the conservation of blood loss during delivery."

The increase in the number of hospital deliveries in the metropolitan area is partly responsible for the increasing number of deliveries by the so-called prophylactic low forceps and episiotomy, especially in the primipara. The availability of anesthesia and the perhaps too frequent use of analgesic and amnesic drugs in unphysiologic doses during the first stage of labor are resulting in many private patients being unwilling or unable to deliver their babies spontaneously. Without going into the pros and cons of this subject it is a well known fact that including the so-called prophylactic low forceps or forceps controlled deliveries the operative incidence in private hospitals often exceeds 50 per cent while in public hospitals it may be less than 10 per cent. This would seem to indicate that many of our low forcep deliveries are unnecessary, yet statistics from reliable maternity services would indicate that the morbidity is not increased by this procedure in skilled hands. Be that as it may, the indiscriminate recourse *in general* to episiotomies and forceps deliveries does increase the likelihood of increased blood loss from either uterine or perineal sources. An episiotomy that is done before the baby's head distends the perineum should not be allowed to bleed; either manual pressure must be made with sterile gauze or ligatures taken so that a considerable source of blood loss is eliminated. This bleeding, if added to several hundred cc. of uterine bleeding, might well total a postpartem hemorrhage.

WHEN a patient is allowed to deliver spontaneously without anesthesia the baby is gradually extruded from the uterus during one or more contractions. The uterus then contracts down physiologically and the bleeding is usually small in amount. When an anesthetic is used the baby is often hastily withdrawn from the uterine cavity and the contraction of the uterus delayed. Anesthesia may delay the separation of the placenta with resultant increase in blood loss. To lessen the chance of postpartem hemorrhage it has been the practice in some hospitals to give pituitrin at the end of the second stage and no increase in the incidence of delayed separation or manual removal of placenta has been noted. This was our experience at Meadowbrook Hospital from July, 1937 to April, 1938. The use of pituitrin has been abandoned on some obstetrical services in favor of the newer ergonovine products because the uterine contractions produced by ergonovine are longer sustained. Uterine motility tests at Chicago Lying-In Hospital have demonstrated waves of relaxation of contractions following the use of pituitrin that do not occur following the use of ergonovine. It is felt that pituitrin is contraindicated in toxemias due to the resultant elevation of blood pressure and some have even questioned the sterility of pituitrin.

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THE National Committee of Maternal Welfare in its booklet "Maternal Care," edited by Dr. Fred Adair, says in the section on the "Management of the Third Stage": "Ergonovine should never be used as a routine before the placenta is expelled." This is good sound general advice. However, from personal experience with the use of pituitrin at the end of the second stage, I feel that the number of postpartem hemorrhages and retained placentae was reduced and reasoned that if pituitrin is of value, a better drug should be of greater value. Accordingly, since last April, at Meadowbrook Hospital, in some 200 deliveries we have used 0.2 mg. of ergonovine intramuscularly at the end of the second stage as well as an additional dose at the end of the third stage. Our series is not completed and we will reserve conclusions until 1000 deliveries have taken place with this routine.

Since last November, at Nassau Hospital, I have used this routine with satisfactory results in my private cases. When an assistant is available I prefer to have it given intravenously as soon as the baby's head has crowned and the anterior shoulder has rotated under the symphysis and it is apparent that shoulder arrest will not occur. Within one minute a uterine contraction occurs and the baby is allowed to be literally pushed out of the uterine cavity by the ergonovine. The anesthesia (ethylene-O_2) is usually stopped and within a few minutes (seldom over five) the placenta has completely separated and can be easily expressed if necessary. It is most important not to massage, rub or hold the uterus after the baby is born while waiting for the placenta to separate. Before the patient is out of the anesthesia the placenta has been expressed and undivided attention may be given to the episiotomy repair. A second intramuscular dose of ergonovine insures a firm uterus while this is being done under a resumed anesthesia.

It is surprising how little blood is lost, usually only that within the sac of membranes. It is not always possible to have the ergonovine given intravenously by an assistant in the delivery room, but if given intramuscularly it is almost as quick in its action.

IN closing, I wish to emphasize that premature attempts to express the placenta before it has completely separated may cause an increased incidence of retained placentae; the uterus must be left absolutely alone, not held or massaged.

The success of this method of control of blood loss seems to depend on the help that ergonovine gives a physiologic procedure, and on purely theoretical grounds the best results should occur when the normal physiology of labor and delivery is aided rather than opposed.

This technic has been used for some time at the Chicago Lying-In Hospital and no originality in method is presumed. It is not recommended for routine home deliveries and should rather be reserved for well organized obstetric divisions of general hospitals or for maternity hospitals proper.

370 HEMPSTEAD AVENUE.

SPASTIC PARALYSIS

Spastic paralysis is a condition in which the normal pull or tightness of muscles is increased, due to a loss by injury or disease of some of the connecting nerve fibers or cells of the brain. The upper motor nerve centers in the brain normally have a quieting effect on the muscles, in addition to the power of sending messages to the muscles to move. It is therefore evident that if a certain area of the brain is damaged, the muscles to which this area supplies the controlling nerve fibers will act wildly, without any sense or reason, and will become much more tight and rigid than they should be. This excessive tightness or pulling produces a deformity.—P. M. Girard, M. D. In *Tri-State Medical Journal*, June, 1938.

Thyroid Disease
FROM THE SURGICAL STANDPOINT

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NO operative procedure requires more careful preoperative treatment, choice of the optimum time for operation, choice of anesthesia, attention to operative detail, and postoperative care than thyroidectomy. In return, no patient is more grateful or the results more satisfactory or gratifying to the surgeon than the case who has had a well-timed, carefully planned operation for goiter. The relief of symptoms after operation, whether they be cardiac, nervous, or obstructive, is so striking that one can very easily see why the thyroid gland has been called the "governor of the body." Many of these patients are desperate and life is no longer worth living for themselves or for their associates. After operation, they are able to resume their usual duties and their general outlook on life is entirely different.

From the surgical viewpoint, the treatment may be divided into preoperative, operation, and postoperative stages.

Preoperative Treatment

HOSPITALIZATION and a few days of bedrest will accomplish more than weeks at home. The patient should be allowed up for one or two hours daily and visitors restricted to one or two members of the family and then only for short periods of time. A high caloric diet, with from three to four thousand calories per day, with avoidance of tea, coffee, alcohol, and tobacco, is indicated. Sedatives to insure rest are given regularly; phenobarbital has been extensively used with good results. After twenty-four to forty-eight hours of bedrest, during which time the patient becomes acclimated, improvement is noted and iodine therapy instituted. This applies, of course, only to the patient showing some degree of thyrotoxicosis. The maximum improvement and, therefore, the optimum time for operation, can be expected in seven to fourteen days after iodine has been started. The amount of iodine prescribed daily varies with individual operators—8 to 10 minims t.i.d., given in milk or grapejuice, seems to be as effective as the larger doses. The surgeon is faced with a real problem when the patient has been given iodine for a long period before operation is planned. It is a well established fact that even when discontinued for a considerable period, when given again the response to the drug is not so satisfactory as when given the first time. These patients also develop an iodine hyperthyroidism which makes operation much more hazardous. Too much emphasis cannot be put on the indiscriminate and prolonged use of iodine before operation.

Anesthesia

ETHER is still advocated as being the safest anesthesia, but while this may be true in the general surgical case, it is certainly not true with goiter. The relatively long period of induction and the stimulation are not to be desired. Avertin has its enthusiastic supporters and much can be said in its favor, but there are disadvantages also and not the least of these is the fact that the patient who has received avertin requires specialing postoperatively to prevent the respiratory obstruction resulting from the relaxation of the lower jaw.

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Novocain block or local infiltration is satisfactory in many instances after preliminary medication as stressed by Crile many years ago when he advanced his ideas on anoci-association. Even when this is supplemented by inhalation anesthesia, the postoperative discomfort and reaction seem to be diminished. The occasional novocain reaction is prevented by the use of some barbiturate in the preoperative medication. The best anesthetic, like the best of anything, is the one that gives the most satisfactory results in the experience of the operator.

To be recommended is the use of nembutal gr. 1½ to grs. iii two hours before operation, HMC #2 (hyoscine gr. 1/200, morphine gr. 1/8) 1½ hours before operation, to be repeated 45 minutes preoperatively; infiltration of the neck with ½ per cent novocain and, if necessary, supplemented with ethylene and oxygen.

The majority of the patients so treated have little if any recollection of the operation, frequently no nausea or vomiting, and a minimum of discomfort.

Operation

THOSE interested in the surgical treatment of thyroid disease are familiar with the variations in operative technique. Lahey, in his clinic, insists on the exposure and identification of the parathyroids and the recurrent nerves. While this may be desirable, it seems unnecessary and in many cases difficult or impossible. Adequate exposure is essential but it is not always necessary to divide the strap muscles.

Silk is the ideal suture material for thyroidectomy; a minimum of reaction is produced by it. In the presence of acute inflammation in the gland or skin (as a pustular acne), catgut is preferable.

The majority of cases offer no great difficulty, but the extremely toxic or poor risk cases tax the operator's judgment as few other conditions do.

Since the advent of the use of iodine, the mortality has dropped tremendously.

Ligation of one or more poles may be indicated: a polar ligation is the term used rather than one referring to individual vessels, because so often the branches can be missed.

A lobectomy and a live patient is preferable to a well executed operation and a dead patient.

When time is a great factor in saving a patient, the neck can be packed with plain gauze or gauze impregnated with acriflavine and a secondary closure done when the patient's condition warrants, as recommended by Tinker.

Drainage of the neck in toxic cases is advisable. In the non-toxic or mildly toxic cases, many necks can be closed without drainage, especially when silk has been used. Bringing the drain out at the angle of the wound rather than the midline gives a better scar and prevents to a great extent the tracheal tug with the act of swallowing.

Postoperative Treatment

INSURING rest by the use of sedatives is most important; the bromides per rectum; nembutal or trional with codeine in a suppository has proven adequate in many cases; morphine or morphine and hyoscine may be necessary. The objection that many surgeons have to hyoscine seems unwarranted and it has not proven to be a "dangerous drug" or to excite any greater number of patients than are excited by the use of morphine alone.

Fluids in large amounts by proctoclysis and intravenously are necessary until the patient can swallow comfortably, which is usually the second postoperative day.

The routine use of iodine postoperatively is a debatable subject but it seems logical to give it in the very toxic patients: if it is indicated in the treatment of a thyroid crisis why not use it as a prophylactic measure?

The treatment of the serious postoperative crisis consists of large amounts of glucose and saline solution intravenously, intravenous or subcutaneous iodine in the form of sodium iodide, and oxygen by use of nasal catheters or the oxygen tent.

In the short time alloted for this paper, many minor but important points have been omitted. Only a few of the outstanding principles have been considered.

PROFESSIONAL BUILDING.

THE TREATMENT OF *Coronary Thrombosis*

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IN as short a time as fifteen minutes it is impossible to give a complete discussion of a subject like coronary thrombosis. Hence, I shall confine my remarks to treatment.

Physicians and even the laity in the past twenty years have gradually become coronary-minded. The moment anyone gets precordial, substernal, or epigastric pain, the physician, usually, or the layman, often, thinks of a coronary thrombosis as a possible cause. Coronary disease in general, and coronary thrombosis in particular, have therefore become diagnosed with increasing frequency. The electrocardiogram has become recognized as a necessary diagnostic agent, and with the development of precordial electrocardiography, both diagnosis and location of the infarct, if present, leave little to the imagination in the vast majority of cases. Diagnosis, therefore, has become more foolproof.

Such is not the case with treatment. Patients suspected of coronary thrombosis are often improperly treated and grave chances taken with their lives and their future. Therefore, it seems well worth while to spend the few minutes at my disposal in the discussion of a few general principles of treatment.

FIRST of all, a coronary occlusion being a grave insult to the heart, all strain should be relieved. The patient should be made as comfortable as possible and then not moved. At the start he is usually more comfortable in a semi-sitting position but should be propped up so that there is no exertion in maintaining his posture. Morphine is the drug of choice and the only one that offers any relief, and that only when given in comparatively large doses. It must be remembered that the nitrite group gives no relief in coronary thrombosis and that with a falling blood pressure it is definitely contra-indicated. In any cardiac pain that has persisted after a few minutes of rest, morphine should be used. Morphine should be given alone and not with atropine. The latter accelerates the heart. A half-grain dose should be given at once except in the case of the aged, when a quarter grain may suffice. If there is no relief within an hour, another quarter grain may be given. Coronary cases withstand large doses of morphine without untoward effects, and unfortunately, often without much relief. Some patients do not tolerate morphine and, in such, pantopon or dilaudid may be used, preferably pantopon, as dilaudid is certainly not as effective in coronary thrombosis. Do not waste time in temporizing with small doses of a narcotic. They will have no effect and only prolong the agony of the patient.

If no relief is manifested, oxygen should be administered, as a combination of morphine and oxygen will often give relief when morphine alone does not. The oxygen should be continued until the pain has been absent several hours. Morphine may be needed in frequent doses for forty-eight hours. Heat to the precordium may be of some benefit. No other treatment is necessary at the start.

If vomiting ensues, small sips of an alkaline water may help. Iced drinks are contra-indicated. Often the vomiting is laid to the morphine but it must be remembered that the condition itself causes vomiting. Glucose is also useful. This will be discussed later.

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No food should be given by mouth for at least the first twenty-four hours, other than warm drinks of broth or cool drinks of alkaline water for the vomiting. The room should be kept quiet and no visitors, not even the family, permitted in the room.

PHYSICAL examination must not disturb the patient. He should not be turned over or asked to sit up. The blood pressure should be carefully followed and also the pulse rate and rhythm, but these can be determined without disturbing him. The temperature should be taken by rectum. The blood pressure is apt to rise during the pain and then fall later, either rapidly or slowly. Unless the blood pressure falls below a systolic of 90 mm. or the pulse pressure below 15-20 mm. do nothing about it. It will come back by itself in due time. If it falls below these critical levels, then caffeine sodium benzoate, a full ampoule, may be given every three or four hours. If the systolic blood pressure falls below 70 and remains there for any length of time, death will ensue, so that an effort must be made to keep it above the critical level. Although adrenalin is tabooed by many cardiologists, I have never seen it do any harm and, in severe cases of circulatory collapse, I have felt that more than one case has been tided over by the use of caffeine and adrenalin, given alternately every two hours. Caffeine alone is all that is necessary in the average case together with the continuous use of oxygen. Digitalis should practically never be used in the early stages. Signs of heart failure will frequently ensue, but usually severe congestive failure is a late result, and the congestive râles at the bases of the lungs and the dyspnea that appear in most cases are best not treated with digitalis. This drug stimulates the heart muscle, which is the very thing we do not want to do. With signs of early failure, with persistent vomiting or very low blood pressure, intravenous glucose 50 per cent in 50 cc. doses may be given. It is a good stimulant to diuresis and good nourishment for the heart muscle.

Quinidine sulphate is indicated if an arrhythmia develops. Ventricular premature contractions often develop and may be the forerunner of ventricular tachycardia. This is to be prevented as it may lead to ventricular fibrillation. Some cardiologists give quinidine as a routine but that seems to me to be rather drastic. It can be started as soon as occasional premature contractions appear. Three grain doses three times a day is often sufficient. If not, it can be increased gradually until the rhythm is restored. If ventricular tachycardia does ensue, then larger doses must be given.

The bowels are often a problem. Mineral oil, one ounce twice a day, is a good routine. Enemata are to be avoided as they require straining and the use of a bedpan afterwards. A small colonic irrigation is less strain on the average patient than an enema. Many patients, especially men, and most of the cases are in men, cannot use a bedpan without a great deal of exertion. In such it seems to me that a commode beside the bed, onto which the patient may be slowly assisted, involves less exertion than struggling with a bedpan. This, of course, cannot be permitted the first few days. If the bowels do not move the first few days, it is better to let them alone than to use cathartics or enemata.

THE average case feels pretty well after the first few days and wants to get up. It is a hard and fast rule that every patient must be kept in bed at least six weeks and severe cases even longer. The period of greatest softening is from the third to the fifteenth day, and healing does not even commence until after that. It is probably nearly sixty days before solid healing takes place and six weeks is certainly the minimum in bed. When the patient does start to get up he must do so gradually. A half hour out of bed twice a day with an increase of not more than fifteen minutes a day is as fast as any case should be permitted to progress. Complications or a delayed rise of blood pressure toward normal may delay this. The patient should not be allowed to walk until he has been sitting up two to three hours at a time. He should not be allowed upon the stairs for at least another month after he starts to get up. Stairs then should be limited to once a day. The very minimum should be six

additional weeks in renewing activity, and as much longer as it is possible for the patient to take is advisable. If every patient could take six months in convalescence we should have fewer recurrences and better end results. For several months he should spend twelve hours in bed at night and at least an hour in the afternoon.

After the first few days, soft diet may be allowed, but a low caloric diet of not more than 1000 to 1200 calories is all that should be permitted at any time during convalescence. Patients who are overweight must reduce. No heavy meals should ever be allowed in the future. Higher caloric diets may be allowed in the undernourished, according to individual needs.

Alcohol may be permitted, but tobacco should be forbidden. While there is some dispute over the effects of tobacco, the present trend is to forbid its use.

No medication is necessary after the morphine and caffeine, if used, are stopped, except that a sedative may be necessary to allay restlessness and induce sleep. A mild one such as phenobarbital may be used or if necessary a stronger chloral-bromide mixture may be indicated. The xanthine group is of no value in coronary thrombosis.

MANY cases develop congestive heart failure when they renew activity, especially the hypertensives who have had a persistent fall in blood pressure. These must be digitalized as any other case of congestive failure. Occasionally, a severe case of congestive failure may develop early and digitalis or diuretics may have to be used, but, as a general rule, digitalis should not be used in the early stages. Other complications such as systemic or pulmonary embolism are to be treated as they would be were the embolism from a different source.

The family should always be informed of the danger of sudden death, no matter how mild the case may seem. Under no circumstances should a case be allowed out of bed early because the patient seems to have no symptoms and apparently is doing well. It is courting disaster to do so. An infarct is an infarct. None are better than others but some are worse than others.

IN conclusion, let me state that the prime essential in treatment of any case of coronary thrombosis is rest and quiet, and the longer the rest and the more prolonged and gradual the convalescence and return to activity, the better the results in the long run. The increasing liberalism and leaning to the left that seem to be the recent trend in politics cannot be allowed to apply to cardiology, for good results can be obtained only by conservation and leaning to the extreme right.

PROFESSIONAL BUILDING.

HIGH CARBOHYDRATE—LOW FAT DIET IN DIABETES MELLITUS

It seems rational in the treatment of diabetes mellitus (hypoinsulinism) to adopt a dietary regimen directed towards increasing insulin production, and in promoting the storage of glycogen in the liver, thus facilitating carbohydrate metabolism. On such a dietary regime, blood sugar levels are lowered, the severity of the disease is ameliorated, the dangers from complications, such as acidosis, arteriosclerosis and gangrene are decreased. . . .

We are convinced of the soundness of the nutritional principles upon which the high carbohydrate-low fat diets are based; and our experience with this innovation in diabetic therapy over a three year period has been so pleasing that we have adopted it whenever practicable in uncomplicated diabetes. This does not mean that we use the same diet in every uncomplicated case of diabetes; because no two diabetics present exactly the same problems in nutrition and treatment, and it is just as necessary to prepare a diet suited to the needs of the individual under treatment as when the low carbohydrate-high fat diets were used.—Seale Harris, M.D. and Seale Harris, Jr., M.D. In *American Journal of Digestive Diseases*, April, 1938.

ASSOCIATED PHYSICIANS OF LONG ISLAND

Successful Outing of Associated Physicians of Long Island Held in Long Beach, Sept. 29. Physicians View Ravages of Hurricane

THE hurricane which ravaged the ocean front of Long Island destroyed the boardwalk and cabana colony of Lido Country Club at Long Beach, Long Island, but fortunately spared the golf course. The autumn outing of the Associated Physicians of Long Island was scheduled there for September 29th and was well attended. The members strolled along the water front and viewed with amazement the damage caused by the gales of hurricane violence.

The scientific program in the Card Room of the Lido Club was presented by members of the staff of Meadowbrook Hospital under the guidance of Dr. Carl Hettesheimer. The general subject of thrombosis of the longitudinal sinus was reviewed and illustrated by a case history by Dr. David Edward Overton, stressing the points of interest from the standpoint of a pediatrician, and Dr. Harold Merwarth of Brooklyn discussed the neurologic features, showing lantern slides depicting the anatomic relations. Dr. George Borden Granger presented some important considerations in conserving blood loss in the conduct of labor, quoting figures from Meadowbrook Hospital where ergonovine has been successfully employed in the second stage of labor.

Discussion by Dr. William Sidney Smith of Brooklyn compared the results of this suburban hospital with those of the Brooklyn Hospital and reported his experiences with pituitrin and other blood-saving factors. Thyroid disease was quite completely covered from the surgical standpoint by Dr. A. S. Warinner, who stressed his experiences in the use of iodine. Discussion of his paper was lively and a number of members participated. The treatment of coronary thrombosis was well covered in a paper by Dr. Louis H. Bauer. Discussion by Dr. J. Hamilton Crawford of Brooklyn stressed what Dr. Bauer had emphasized, the necessity for a long convalescence, even in the face of apparent recovery of the patient.

The business meeting was brief. Dr. James Jarrott of Hempstead was elected to membership. The president, Dr. Otho C. Hudson, appointed a nominating committee, Dr. Fett, Dr. Jaques, Dr. Boettiger and Dr. Frank Overton, to bring a slate of candidates for offices at the regular annual meeting. Dr. Thomas B. Wood reported that the Lincoln Sign Company was ready to make the plaque to commemorate the founding of the association in Brooklyn.

Dinner in a room overlooking the Atlantic Ocean was an unusually pleasant affair and favorable comments from members were in tribute to the committee on entertainment and to the chef of the club. Following this convivial affair was a treat to the eye and ear. One of our members, Dr. Wendell Hughes, a prominent Long Island ophthalmologist, showed brilliant motion pictures which he took while enjoying a Mediterranean cruise en route to the International Eye Congress in Cairo, Egypt. The skill with which these pictures were made won the admiration of all the members.

The Annual Meeting of Associated Physicians of Long Island will be held Saturday, Jan. 28, 1939, in Norwegian Hospital and Montauk Club, Brooklyn.

THE TREATMENT OF PNEUMONIA

Two agents which closely rival specific measures in the treatment of pneumonia have gradually been developed. These are sugar and oxygen. We must all agree that with less than an adequate amount of oxygen and sugar in the blood even serum of the specific type will fail.—Charles F. Gormly, M. D. In *Rhode Island Medical Journal*, June, 1938.

A Historical Review

OF THE ASSOCIATED PHYSICIANS OF LONG ISLAND

OTHO C. HUDSON, M.D., F.A.C.S.
Hempstead, New York

MEMBERS—IN greeting, allow me to express my hearty thanks for the honor conferred upon me, and to ask for your cooperation and assistance in carrying out the work of the society. As it is customary for the president to give an address to this Association, this may fall into three types: first, reminiscences, which I surely am too young to do; second, soothsaying or star gazing and prophesying, which also I do not feel capable of doing; and third, a review of the past of this Association's existence.

The Associated Physicians is in its fortieth year of continued success. The Association was organized at the Union League Club in Brooklyn, on April 14, 1898 with Dr. Louis N. Lanehart as Chairman and Dr. Robert J. Morrison as Secretary, for the purpose of bringing into closer relationship the members of the regular County Medical Societies of Long Island.

The name of the Association was selected as the Associated Physicians of Long Island. The home of the Association was designated as Brooklyn and it was decided that three meetings a year, the annual meeting in January, the spring meeting in June on Long Island, and an autumn meeting on Long Island, preferably in Nassau County, should be held. Each county was to be represented by a Vice President.

The first regular meeting was held in Garden City on Long Island on June 8, 1898. Among those present were Doctors:

William Browning
Calvin Barber
William Maddren
George MacNaughton
Charles Stewart
Alexander J. C. Skene
Robert J. Morrison
George R. Fowler
Joshua M. VanCott
Charles D. Napier
James M. Winfield, all of Kings
George K. Meynen
Louis N. Lanehart, of Queens
William H. Ross
William A. Hulse
Arthur H. Terry, of Suffolk.

THE first officers were:

Dr. William Browning of Brooklyn, President
Dr. Louis N. Lanehart of Hempstead, First Vice President
Dr. William A. Hulse of Bay Shore, Second Vice President
Dr. Charles Jewett of Brooklyn, Third Vice President
Dr. Robert J. Morrison of Brooklyn, Secretary
Dr. Joseph H. Hunt of Brooklyn, Historian
Dr. Henry A. Fairbairn of Brooklyn, Chairman of the Executive Committee

At the first meeting three papers were read by the following men:

Drs. Henry A. Fairbairn on Prognosis in Chronic Nephritis; James M. Winfield on a Report of a Case of Nodular Leprosy, with Demonstration of the Bacillus; and by Ezra A. Wilson on Immunity.

ON October 17th, 1899 the Association was incorporated "To bring into closer relationship the members of the various county societies of Long Island; to supplement the work of the county societies; to accomplish by cencentrated

An Address before the Dinner of Past Presidents of The Associated Physicians of Long Island, Brooklyn, N. Y., March 19, 1938.

action the proper regulation of matters pertaining to the general hygiene of the Island; to foster higher ethical standards among its members; and to bring together socially, as well as scientifically, the various medical and surgical workers of Long Island."

During the past thirty-nine years this Association has fulfilled all the hopes of its founders. The following men form the "House of Lords" of the past presidents in the order of which they served:

1898-1899	William Browning
1899-1900	Louis N. Lanehart
1900-1901	James MacFarlane Winfield
1901-1902	William B. Gibson
1902-1903	Calvin F. Barber
1903-1904	William H. Ross
1904-1905	Robert J. Morrison
1905-1906	William B. Savage
1906-1907	Elias H. Bartley
1907-1908	Arthur H. Terry
1908-1909	H. Beeckman Delatour
1909-1910	Frank T. Delano
1910-1911	Thomas R. French
1911-1912	Frank Overton
1912-1913	William B. Brinsmade
1913-1914	Samuel Hendrickson
1914-1915	James P. Warbasse
1915-1916	Guy H. Turrell
1916-1917	Dudley Roberts
1917-1918	John C. Schmuck
1918-1919	Lefferts A. McClelland
1919-1920	William A. Hulse
1920-1921	Henry G. Webster
1921-1922	Harris A. Houghton
1922-1923	Joshua M. VanCott
1923-1924	Hugh Halsey
1924-1925	H. D. Schenck
1925-1926	Arthur D. Jaques
1926-1927	Walter A. Sherwood
1927-1928	L. Howard Moss
1928-1929	Walter Truslow
1929-1930	Edwin P. Kolb
1930-1931	Charles H. Goodrich
1931-1932	Henry C. Courten
1932-1933	Jacques C. Rushmore
1933-1934	William J. Malcolm
1934-1935	Thomas B. Wood
1935-1936	Herbert C. Fett
1936-1937	Wilbur C. Travis
1937-1938	Charles A. Anderson

THE seal of the Association was designed by Dr. Robert L. Dickinson and adopted in 1901.

During the earlier meetings on the Island, Dr. Frank Valentine, through his connections with the Long Island Railroad, secured either special trains or a reduction in railroad fares to the Island meetings.

Major General Leonard Wood and President Theodore Roosevelt were made Honorary Members of this organization in 1905. Mr. Roosevelt delivered two addresses, and Major General Wood one address, to the Association.

The Transactions of the Associated Physicians of Long Island were first published in 1900 and continued until 1906, when they were discontinued and the *Long Island Medical Journal* appeared as the official organ of this society. Dr. P. M. Pilcher was chosen the first editor and remained in that position until 1914, when he was succeeded by Dr. H. G. Webster. In 1923, Dr. H. G. Webster was forced to resign because of ill health and Dr. Frank Overton was appointed. In 1926 Dr. Overton resigned and was succeeded by Dr. A. N. Thomson. Dr. Thomson continued as editor until the close of 1930, when the Journal was merged with the MEDICAL TIMES of New York. Dr. A. C. Jacobson was editor of the MEDICAL TIMES at that time and continued as the editor of the combined Journals, thereupon called the MEDICAL TIMES AND LONG ISLAND MEDICAL JOURNAL.

THERE have been many scientific articles on every conceivable subject in the Transactions and Journals. The Journal is exchanged with many foreign and domestic medical publications. The exchanges and books for review are the property of the Association and are deposited in the custody of the Library of the Kings County Medical Society. As a member of this Association, you have the privilege of receiving the useful aid of the Kings County Medical Library, of which Mr. Charles Frankenberger is Librarian.

Some of the high lights of your achievements are: In 1912 two hundred members pledged their bodies to the dissecting table, if necessary, after stating that it was the duty of physicians to educate the public that autopsies, especially in cases where the cause of death was not clear to medical science, would be of advantage to humanity.

In 1913 Dr. J. E. McWhorter of the Crocker Institute for Cancer Research showed medical movies, for the first time, of the development of an egg to a chicken.

The Historical Committee has published obituary notices in the Journal. We urge all individuals to fill out their biographical blanks, when they receive them, so that they may be filed with the Kings County Medical Society. These records have lapsed recently and we suggest that the Committee secure the information up to date with the addition of a photograph of each man.

WE believe that it would be very appropriate to erect in the Kings County Medical Society Building in Brooklyn, if possible, a plaque to "The Founders" of this organization as a commemoration of its fortieth year.

In 1914 there were 862 members and in 1915 the all time high of 909 was reached. In 1937 the Directors voted to limit the membership to 600, which limitation was adopted at a regular meeting.

In 1914, the present much harassing topic of State Medicine was discussed and on January 31, 1914 Dr. J. P. Warbasse stated to this Society that the Lloyd-George Insurance Bill in England was confiscation of the medical profession and predicted a similar bill for the United States.

The Committee on Public Health was appointed in 1901 and has done work in investigation of the water supply and in insular tuberculosis, made surveys of typhoid fever, tetanus, and malaria in 1907, and in 1915 through its Chairman, Dr. A. D. Jaques of the Nassau-Suffolk Mosquito Extermination Committee, urged the passage of the mosquito control legislation at Albany and helped draft the bill passed in 1916 for Nassau County.

During the World War, when the ranks were depleted by members being in the Service, the Association continued strong. In 1918, on June 22nd, a meeting was held at Camp Upton at the invitation of the commanding medical officer of the base hospital, Lieutenant-Colonel J. D. Whitham.

IN summarizing the successes of the past forty years, the statement made by Dr. J. M. Winfield in 1923 is still true: "One feels that this medical organization was not established in vain, for when it has reached the century mark, the Associated Physicians of Long Island will be one of the most powerful medical societies of this country, if not of the world. It was organized for service, its achievements have been arrived at through service, and its future aim will be service. In closing all that is left to say is go forward; be strong and fear not; in service lies success."

PROFESSIONAL BUILDING.

THE PHILOSOPHY OF THE DIABETIC LIFE

Teaching the patient the right philosophy is the fundamental problem in the treatment of any chronic disease. This statement applies more specifically to diabetes mellitus than to other chronic diseases because of the better prognosis. Results of treatment of this condition are dependent upon a faithful continuity in details of treatment but unless the diabetic patient develops a desirable philosophy, long time control of the disease is seldom consistent. . . .

Equipped with practical information which he uses each day, free from fear of diabetes or his future, with no resentment over his lot, the diabetic is in the best possible condition for the realization of the diabetic ideal. Such a person cannot then be classified as a chronic patient. Diabetics attaining these ideals are about us on all sides. There should be more of them. There will be more of them when the members of the medical profession appreciate more keenly their responsibility in teaching the philosophy of the diabetic life.—Blair Holcomb, M.D. In *American Journal of Digestive Diseases*, April, 1938.

Economics

Department Edited by Thomas A. McGoldrick, M.D., LL.D.

CURRENT THOUGHT

FREDERIC E. ELLIOTT, M.D.
Brooklyn, N. Y.

WHEN the Special Meeting of the House of Delegates of the *American Medical Association* endorsed and approved "medical expense indemnity" insurance, the medical profession took a long stride toward the solution of the economic difficulties which are created by the "doctor's bill."

The old wheeze "that where there is smoke there is fire" was never more close to the truth than here in this question about the "cost of medical care." Of course, most of the so-called surveys and studies have shot wide of the mark. They have invariably been designed to build up statistical and emotional arguments for the creation of some sort of bureaucratic control and regulation of the medical profession. The basic facts never have been thrown into plain view.

During the past two decades many changes have come upon our social environment. For one, the money cost of a medical education has increased more than tenfold, and the required time and effort has beeen extended from two up to fifteen or more years. In this same period a system for the "dole of free medical care," through public and volunteer clinics and hospitals, has grown to the magnitude of "big business." Thus, while the need of greater financial support for the medical service of our countrymen has grown with the progressive improvements of that service, the sources of such support have diminished. The medical profession has encouraged the development of a system which has called for more and more gratuitous service to the sick and injured.

ONE direct consequence of this trend has been a gradually increasing charge for medical service made to those who pay doctors' bills. Practically, this has constituted a system of indirect taxation administered through the members of the profession—a system in which those who compensated their doctors have been made to pay not only for the services which they received but also for the services rendered to those "on the dole." Not only have the very rich been "taxed" by higher fees, but in recent years the moderately circumstanced people have been faced with higher charges for medical services. In some instances even those in the lower income levels, who have sought to maintain self-reliance, have been subjected to charges which took an unreasonable share of their resources.

Another consequence has been that many physicians, particularly the younger element, have developed a fixed attention on those services which yield the larger "unit fees," and they have lost sight of the greater opportunities in the aggregate of the smaller fees. Our young doctors come out of their hospital training with their thoughts focused on major services and large fees, with the result that the opportunity for development of a practice in the smaller fee field is overlooked or neglected. The competition of the "free clinic" has, of course, aggravated this pernicious trend.

THE world-wide upset of general economic conditions and its resulting general economic distress in personal affairs has given the proponents of "socialization" an opportunity to advocate with good effect a plan of "state medicine." They have undertaken to turn the need for some form of collective action to serve their own peculiar philosophy of community life.

"Compulsory health insurance" of the German pattern has been sponsored with

well-financed propaganda. The fact that such a system has failed to deliver its vaunted advantages has been obscured. The demonstrated defects of such a system need not be detailed here. The point we would make is that failure has arisen from basic and fundamental faults. Of such faults, we shall speak now of only two.

Whenever there is organization for the provision of medical service through collective action, there must be an established "authority of administration." In all "compulsory" systems this "authority" has been dominated by politicians and lay control. Effort has been made to "rule and regulate" human conduct and deportment in a field which cannot be governed by any simple code. And because of this fact "red tape" interference and embarrassment to the normal relation of the doctor with his patient occurs. The natural reaction of antagonism on the part of the members of the profession to such "authority" has been disruptive in its effects upon medical service. And this has been reflected in all the human relations in such a system.

ANOTHER basic fault is the undertaking of the provision of service for minor and trivial complaints. Linked with "cash benefits" for the unemployment incident to sickness disability, these systems are confronted with a large amount of malingering and exaggeration of complaints and unreasonable demands for unneeded attention. The time and effort of the medical service is wasted upon unimportant details of such service and reports thereon. The expense of administration of such activity creates the need for a large staff of personnel. And it generally develops that the number of lay clerks and other people employed to run the system's administration becomes greater than the number of physicians required to render the actual medical care of the sick. The resources of the system are dissipated on salary disbursements of such lay administration and upon the care of the unimportant medical needs—leaving insufficient for fair and proper remuneration of the medical profession. Demoralization and discouragement of the medical service are natural sequelae.

The failure of "compulsory health insurance," for the above and many other reasons, does not mean that the problem cannot be solved. We believe that an American approach to a solution lies in "medical expense indemnity" insurance. In this we see the preservation of the patient's individual independence and spirit of self-reliance, a system of aid made available to all who need it (not just for those who are employed in large groups), and we see a system which will provide reasonable and proper financial support for the maintenance and further progress of modern medicine.

THE September issue of the Kings County Medical Society *Bulletin* carried the first public notice of the recent organization of the Associated Medical Service of New York. In brief, we understand that this is a non-profit, mutual or cooperative association which intends to provide indemnity for major medical expenses wherever the doctor works. It will be necessary to obtain amendment of the present Insurance Law before this Association may legally engage in such insurance practice. An act has been prepared for such purpose by the Joint Legislative Committee on Recodification of the Insurance Law, and we are advised that Mr. R. Foster Piper, Assemblyman from Buffalo and chairman of the Committee, will introduce this at the beginning of the State Legislative Session in January. Based upon the action of the House of Delegates of the American Medical Association, the medical profession and the State Medical Society will give this act support to assure its early enactment.

The details of the program of administration have not been published. We do know the sponsors of the organization. They are all physicians well experienced in medical practice, and well qualified to plan a system suited to the needs of both the public and the profession.

There is an opportunity for such an organization to render benefits to both the public and the members of the medical profession. It is only upon such a basis that this Association can hope to receive general acceptance and approval.

FROM where we see the picture, the public and the medical profession will

owe the founders of this enterprise a deep debt of gratitude for the responsibilities and labors which they have shouldered. After all, a system which provides the public with security against the hazard of a large expense for medical care, and which pays each doctor a reasonable remuneration for the services which he renders, would seem to offer an equal opportunity to share in the benefits of what is created. The chief reward which may accrue to the founders of this Association, as we see it, is the satisfaction of seeing a considerable part of this social problem solved. In this plan for medical expense insurance we see a bulwark erected against any form of "state medicine." —*F.E.E.*

THE TREATMENT OF CANCER

There is only one fixed rule for the treatment of cancer and that we got from Donnybrook Fair, "When you see a head, hit it." And like the lad with the shillalah, "Hit hard." You will never have a better chance than your first one. But team work is exceedingly important. At least three agents have proved their value, surgery, x-ray and radium. Each case must be approached with an open mind as to which one agent or combination shall be used.—Peter P. Chase, M.D. In *Rhode Island Medical Journal*, April, 1938.

TREATMENT OF PELLAGRA

TOM DOUGLAS SPIES, WILLIAM BENNETT BEAN, Cincinnati, and ROBBERT E. STONE, Birmingham, Ala. *(Journal A M. A.*, Aug. 13, 1938), say that the observations of Elvehjem, Madden, Strong and Woolley showing that nicotinic acid cures canine blacktongue stimulated several investigators to administer nicotinic acid to human beings with pellagra. Spies, Cooper and Blankerhorn recently reported that in a series of seventeen cases of pellagra, nicotinic acid, nicotinic acid amide and sodium nicotinate dramatically blanched the erythematous dermal lesions, produced healing of the clossitis, stomatitis, vaginitis, urethritis and proctitis, and reduced the amount of porphyrin in the urine to normal.

THE RED TAPE BEGINS TO UNWIND

If any one is in doubt as to what happens under state medicine, the following example should be convincing: In the case of a woman in the state of New York who was ill, attention was given by a local physician, who then notified the relief official that prolonged medical care would be required. The case supervisor for the public welfare official then sent the following letter:

We are enclosing forms which are to be forwarded to the state department where prolonged medical care is needed.

We are asked to send a letter from the doctor with these forms giving a complete medical history of the patient which will include the date of onset of illness, the diagnostic procedure used and any laboratory findings. *The name, strength and quantity of the material used for injections will be reviewed by a state physician.*

The red tape begins to unwind and before the spool runs out all of medical practice may be wrapped in its meshes. —*Jour. A. M. A.*, Aug. 13, 1938.

AUDIOMETRY IN ROUTINE PRACTICE

ISAAC H. JONES and VERN O. KNUDSEN, Los Angeles *(Journal A. M. A.*, Aug. 13, 1938), says that the otolaryngologist is aware of a criticism directed at him. He is known to be devoted to every phase of his work except one field—service to the hard of hearing. Why is this? It seems that the fault is both in the patient and in the physician. At long last the otolaryngologist is beginning to recognize that audiometry is not only a legitimate but a necessary part of his practice. He no longer inquires "Should I have an audiometer?" but rather asks "What kind of an audiometer should I get?"

CANCER

(Charles William Hershiser, B.S. (Rochester), M.D. (Hopkins), F.A.C.S., *German Literature Editor*, and Edward Parnall, A.M. (Harvard), M.D. (Harvard), *Italian Literature Editor*

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Carcinoma OF THE COLON AND RECTUM

Diagnosis

CHARLES J. DRUECK, M.D., F.A.C.S.
Chicago, Ill.

THE repeated admonition of writers that every indefinite symptom of abdominal disturbance must raise the possible diagnosis of cancer is evidence that early symptoms of malignant disease are quite elusive. Tumors of the colon have no specific signs that lead us to suspect the existence of a grave lesion and thus make an early diagnosis possible. The early symptoms may simulate various conditions found in the abdomen, thus rendering the early diagnosis an exceedingly difficult one. However, an early diagnosis is most vital because it is at this time only that surgery offers its greatest cures.

When blood, mucus and pus are discharged with or independently of the stools we are dealing with the complications of an ulcerative stage of bowel disease. Occasionally pain, tenderness and rigidity may furnish a clue as to the nature of the disturbance, but these symptoms are too often evanescent, associated with dietetic indiscretion, or so masked by the seemingly excellent state of health as to direct our attention toward functional rather than organic disease.

The clinical manifestations of tumors of the colon and rectum so closely mimic those of systemic disease that extra-digestive organs receive treatment by mistake.

Hepatic Disease

THE most frequent functional disturbance that leads us astray is hepatic disease. Jaundice, portal obstruction, variation in size, consistency, and shape of the liver are important bedside observations. In the presence of portal obstruction, dilatation of the hemorrhoidal veins may be noted. In both cirrhosis of the liver and in metastatic carcinosis the liver may be enlarged and its consistence increased. Either or both conditions may occur in a middle-aged individual who is chronically, but mildly, ill or who gives a history of prolonged chronic alcoholism or of a syphilitic infection with persistent treatment. Either condition may furnish a further history of malaise, loss of weight, "dyspepsia" and perhaps one or more episodes of slight jaundice. At this stage other symptoms may be so vague that they may have been almost forgotten by the patient, such as transient feelings of fatigability, anorexia, occasional nausea and vomiting, especially in the morning, abdominal pain or unrest or irregularity of the bowel, or the

passage of black stools. Later, the development of ascites demonstrates that the reserve power of the liver has approached its vanishing point.

Anemia

MALIGNANT processes are almost invariably accompanied by hypochromic anemia. It appears that any type of malignancy in almost any tissue is capable of producing anemia, even though the process is not grossly extensive and there is no evidence of metastasis or bone marrow involvement. It has been thought that the malignant process itself either elaborates a product capable of bone marrow inhibition, or the growth utilizes a product necessary for red cell production.

Although the exact mechanism of the anemia of malignancy is unsettled, there do seem to occur degrees of anemia that are entirely out of proportion to the extent of the malignant growth. The anemia in such states is definitely hypochromic. The red cells are reduced in number. This fall in the red cell count is so pronounced as to simulate pernicious anemia. It is often below three million.

Though our patient may be discharging necrotic tissue, pus and blood from the rectum, and the red cell count be as low as following an acute hemorrhage, the leukocytes will be very slightly raised. Ten to twelve thousand is the usual count. Only when the malignancy is far advanced is there a high leukocytosis. The rise in white cells just preceding death has long been recognized and referred to as agonal leukocytosis.

The hemoglobin will be reduced to a greater extent than the red cells, often to 50 per cent, and the color index below one.

A high neutrophil count indicates that the patient's resistance is extremely low.

Anemia is more severe in carcinoma of the right half of the colon than in cancer of the left half.

A careful study of the blood is vital in our classification of the patient as to operable risk. Some surgeons give several small transfusions of blood (100 c.c.) preoperatively to correct the anemia, while others give one large transfusion of 500 c.c. before and immediately following the operation, or both. Patients with low hemoglobin values offer additional risk from reactions after transfusions.

Ileitis and Carcinoma of the Colon

ILEITIS must be considered in a differential diagnosis from carcinoma whenever it attacks the ileum and the cecum. X-ray examination here will be of great assistance. Physical examination will not help much if a large tumefaction is present. Some similarity to cancer exists in the symptoms, such as blood and mucus in the stools, with intermittent diarrhea. There is usually, however, a leukocytosis in ileitis which is absent in carcinoma of the colon except in cases in which perforation and inflammatory reaction have occurred around the cancer.

Diverticulosis

DIVERTICULA of the bowel may cause obstruction at any time. Diverticula other than Meckel's are readily revealed by the x-ray film but it is not always advisable to employ the barium sulfate meal or enema in the presence of obstruction. The symptomatology of the inflamed diverticula (diverticulitis) closely mimics that of the appendix and ofttimes clinically is not distinguishable from it, consisting of pain, nausea, vomiting, localized tenderness and rigidity with an increased leukocyte count. The complications besides obstruction are acute diverticulitis, suppurative peridiverticulitis (abscess) and perforation with peritonitis. Their surgical treatment does not differ from that of similar pathologic lesions dependent on other causes.

Diverticulitis with adhesions may appear identical with those of neoplasm unless diverticuli in other parts of the bowel are visible.

Obesity

THE layman's conception of cancer is always associated with emaciation. However true this may be in the terminal stages of malignant disease of the colon, it is well to remember that even well advanced carcinoma of the colon is frequently found in well nourished individuals, often in the prime of life, and when least expected. Obesity is no guarantee against carcinoma of the

bowel, or for that matter of any part of the body. Carcinomas of the gastro-intestinal tract are frequently found in persons weighing over 200 pounds.

Less Frequent Confusing Conditions

AMONG the less frequently met conditions causing suspicion of tumors of the lower digestive tract are:

1. Extensive adhesions which may cause obstruction, though the clinical history should give the clue;
2. Tuberculosis of the cecum or colon, which is usually associated with advanced pulmonary disease. Hyperplastic tuberculosis of the colon may be clinically indistinguishable from malignant disease but life is prolonged indefinitely by colostomy;
3. Rectal stricture of venereal granuloma;
4. Chronic proctitis.

Abdominal Palpation

A CAREFUL abdominal examination is, of course, demanded in all digestive disturbances, but curiously enough even advanced disease may exist without a tumor mass being palpable through the abdominal wall. When upon abdominal palpation a tumor is palpable in the region of one of the divisions of the colon, a differential diagnosis between similar lesions of other organs in the same neighborhood must be made. Most of the mistakes in such diagnoses occur when a mass is felt in the right iliac fossa.

A lesion in the splenic flexure may be mistaken for a tumor of the spleen or kidney. However, with blood studies and consideration of the general outline and contour of the spleen, one should be able to differentiate between these two conditions.

Lesions in the descending colon are usually of a small constrictive type, and give rise to symptoms of intestinal obstruction. It is very difficult to palpate a tumor in this region.

Localized peritonitis about the diseased bowel is often present.

Digital Palpation

A RECTAL examination should be made a part of every abdominal study. Not only may we find a rectal neoplasm but a pelvic abscess may be found; or an appendix projecting into the pelvis, which does not show upon abdominal palpation, can often be demonstrated. A patient with a carcinoma of the stomach which seems operable may be found to have malignant nodules in the cul-de-sac.

Digital palpation of a neoplasm in the rectum is the surest diagnostic aid. Any non-pedunculated mass having a hard nodular feeling is probably malignant and should be so considered until proven otherwise.

Anyone who has palpated carcinomatous tissue knows the "feel" of cancer. The finger is invaluable in determining fixation and the presence of enlarged nodes. The appearance of cancer through the proctoscope should seldom confuse the examiner. Cancer practically always occurs as a single lesion which appears as a more or less irregular, warty, stubby nodular or cauliflower-like growth in the mucosa, projecting into, or possibly encircling the lumen of the bowel. Cancer usually appears on the posterior wall and gradually encircles the bowel within twelve to eighteen months. Pain does not occur until the disease has invaded the bowel wall and the deeper structures become involved. Cancer may appear as an excavating process on the wall depending upon the extent of growth and trauma. The sharp line of demarcation between the proliferating mass and the adjacent mucosa is distinctive. Biopsy is a conclusive means of diagnosis and should be made if there is any question.

The patient must be examined in various positions, namely: on his back in the lithotomy position—in women this is the gynecologic position; on his side with both knees drawn well up against the abdomen; and then in the knee-chest or inverted position. This change in position is often essential because sometimes in the lithotomy or lateral positions the patient is better able to bear down upon the examiner's finger and thus bring into reach a tumor appreciably farther up the rectum.

Roentgenography

THE diagnosis of growths occurring above the reach of the sigmoidoscope requires the aid of the barium enema

and röntgen ray. Because of the variability of the length of the pelvic loop, its mobility and its tendency to overlap and obscure the outline of portions of the gut, extreme difficulty is experienced, particularly in non-obstructive lesions. The fluoroscopic technic is here of great importance.

Filling defects of the pelvic colon are difficult to demonstrate due to spasm, position of the patient, and lack of canalization.

The rectum and left colon should be thoroughly irrigated in preparation for röntgenographic study in order to avoid errors because of fecal shadows. Fluoroscopic study should always be made while the contrast is being slowly introduced, and double contrast films should be made later. After the discharge of the contrast medium only a thin wall covering remains; the intestine should then be slowly inflated while the gradual unfolding of the intestinal wall is carefully watched.

In the early stage of any inflammatory disease involving the mucosa of the bowel there is hypermotility and the region more acutely affected is usually empty of food or opaque material. It is, therefore, only in the advanced stages of malignant disease that the röntgenologist can satisfactorily show the diseased area.

The part of the bowel immediately cephalad to the obstruction is often markedly distended. A much dilated rectal ampulla very strongly suggests a growth low down in the sigmoid. Why the rectum should be dilated below the growth is not known, but it is a valuable sign, because the lesion is often in a position in which its shadow is exceedingly difficult, if not impossible, to see satisfactorily. These cases are better studied with the sigmoidoscope.

Whenever any doubt exists about any angle of the examination a röntgenographic study by means of a barium enema followed by a double contrast film (and perhaps a barium meal) must always be included and often is a great help. With a continuation of the symptoms, one negative report from the röntgenologist should not settle the possibility of the presence of a tumor.

The points on which carcinoma is röntgenologically diagnosed are: (1) obstruction, which is due to carcinoma in a large percentage of cases; and (2) filling defects. In the advanced cases there is no difficulty. The opaque enema is seen finding its way through the irregular channels in the papillomatous type of growth, or passing in a fine stream through the more fibrotic annular growth. By manipulation the radiologist ascertains whether the bowel is fixed or not, and by tactile sense determines the presence of thickening and perhaps the extent of the growth. Unfortunately, only a small length of the colon can be palpated, for the upper part of the descending colon passes under the costal margin, and growths in the splenic flexure are common. For the diagnosis of these he has to depend entirely on the filling defect.

The diagnosis of early malignant disease is by no means easy, because the colon is so irritable and so liable to spasm. It is sometimes quite impossible to tell whether a filling defect or even an obstruction is due to spasm or to growth. Such patients should be reexamined. In the small number of cases in which both manual examination and röntgenoscopy fail, a biopsy should be made.

1132 East 49th Street.

URETERAL CALCULUS

It is a fairly universal fallacy with most of the laity and a goodly number of physicians as well, when once a renal calculus has descended into the ureter that the patient's troubles are over. To the experienced urologist his troubles have only just begun . . . . .

A calculus in-dwelling in the ureter is fraught with a thousand times the danger to the patient than when it reposes within the kidney pelvis.—Stanley W. Woodruff, M. D. In *Journal of the Medical Society of New Jersey*, April, 1938.

Contemporary Progress

+ Rhinolaryngology +

Calcium Cevitamate in the Treatment of Acute Rhinitis

S. L. RUSHKIN *(Annals of Otology, Rhinology and Laryngology, 47:502, June, 1938)* reports the use of calcium cevitamate—the calcium salt of cevitaminic acid (vitamin C)—in the treatment of acute rhinitis. While the vitamin C may have a certain therapeutic value, as evidenced by "its time-honored use—as citric drinks in the treatment of the common cold," the chief value of the calcium cevitamate, the author believes, is its calcium content. The advantages of the cevitamate is the fact that vitamin C "possesses the unique property of solubilizing and ionizing calcium to a degree not previously obtainable," and thus greatly enhances its absorption either by mouth or by injection. A comparison of the physical properties of calcium cevitamate and calcium gluconate showed a marked difference in solubility and ionization in favor of the former. The author has treated 100 cases of acute rhinitis (common cold), rhinitis complicated by sinusitis, and allergic rhinitis with injections of 3 c.c. of a 15 per cent. solution of calcium cevitamate. Some cases of acute rhinitis treated early were relieved by a single injection. Of the entire series of 100 cases, 42 were completely relieved, usually after one or two injections; these were chiefly cases of acute colds; 55 were markedly improved, including cases of acute rhinitis complicated by sinusitis and nasal allergy; in these cases treatment was continued for a longer period, giving two injections weekly as a rule; 3 cases of a more chronic type showed only moderate improvement. The injections caused no local reactions or discomfort. The author considers that calcium cevitamate is "practically an abortive in the treatment of the common cold."

COMMENT

We are interested in the author's remarks. Although there is no reason to doubt that the vitamins will help materially in increasing the resistance of the patient so that he will throw off a rhinitis more rapidly, we question whether it is necessary to go through the procedure outlined in the majority of cases. As a rule the average acute rhinitis will clear up by itself in the course of a week or so and surely in the length of time mentioned for the injection. We cannot agree that calcium cevitamate is any more of an abortive of a cold than the usual remedies which we have used for so many years.

H. H.

Oral Ragweed Pollen Therapy

T. B. BERNSTEIN and S. M. FEINBERG *(Archives of Internal Medicine, 62:297, August, 1938)* report a trial of oral administration of ragweed pollen in 20 cases with ragweed hay fever and asthma. The initial dose was one drop of a 1:33 extract of the pollen—about 450 times the strength of the initial dose by hypodermic injection. This was gradually increased up to a maximum dose of 10 to 15 drops in most cases, 30 drops in 2 cases. The dose was given three times a day, well diluted. In 18 cases there was no improvement resulting from the treatment; in 2 cases there was some improvement in the hay fever, but one of these patients also had asthma, which was not benefited. In 6 cases, the extract caused marked gastrointestinal symptoms. The authors are inclined to believe that the doses used were not therapeutically active, as experiments on normal persons by determining the reactions produced in sensitized areas indicate that the amount of the antigen reaching the circulation after oral administration is not more than one four thousandth of that demonstrable in the circulation after hypodermic administration in the same unit of time. The tendency of the extract to produce marked local reaction in the gastro-intestinal tract is, however, "a definite obstacle" to the use of larger

doses. The authors conclude that oral pollen therapy is of little value in the treatment of ragweed hay fever—at least in the Middle West (Chicago).

COMMENT

The oral administration of pollens, particularly ragweed, is not new. Schreppegill suggested the use of pollen extracts orally and also the making up of snuff preparations to be used in the nose. Apparently this method of treatment did no more good than that mentioned by the authors.

Incidentally, some doctors have mentioned that they have gotten excellent relief by treating the mucous membrane of the nose with a 95 per cent carbolic solution during the hay fever season.

H. H.

A New Therapy in Chronic Sinusitis

J. D. SHORELL *(Medical Record, 148:55, July 20, 1938)* describes a new method of treatment for chronic sinusitis; the treatment is essentially non-surgical, although such simple procedures as removal of polyps may be carried out. The treatment includes two distinct procedures. In the first place injections of a specially prepared autogenous vaccine in a 2 per cent. aqueous isotonic histidine solution are given. The vaccine is prepared from the purulent secretions of the patient, using a twenty-four hour culture on agar medium and the least amount of heat that will kill the organisms. The dosage of vaccine is increased from 25 million killed bacteria to 500 million; but the dosage of histidine chloride is always 2 c.c. Injections are given two to three times a week, "depending upon the patient's tolerance and reaction." In the second place heat is applied locally by means of hot water propelled through distensible rubber tubes "inserted into the entire length of the nasal cavities, passing over the inferior and middle turbinates, and the ostia of the sinus cavities." The temperature of the circulating water is raised to the desired level by an electric heater and regulated by a rheostat; the degree of heat depends on the patient's tolerance and the severity of the inflammatory disease. The author has found that 80 per cent. of cases of sinus disease can be cured by these combined methods without radical operation.

COMMENT

Although we have not tried the autogenous vaccine in histidine solution, we question very much whether one gets any more relief from such injections than he does from the ordinary method of treatment. In regard to the heat treatment, by placing hot water tubes in the nose (we believe the Elliott machine is used), we gave this method of treatment a thorough tryout some years ago and found that it did very little good. Almost every person living in a large city will be found to have some form of sinusitis. Whether symptoms really amount to anything or not depends mainly on proper hygiene in the nose and keeping the physical condition up to par.

H. H.

Tonsillectomy Under Intravenous Anesthesia

K. Hutchinson and his associates at the Children's Memorial Hospital, Montreal, Canada *(Canadian Medical Association Journal, 39:237, September, 1938)* note the difficulty of selecting a suitable anesthetic for tonsillectomies in children with chronic respiratory diseases—especially tuberculosis. There are "considerable numbers" of such children in whom tonsillectomy is indicated in any children's hospital. In the Montreal hospital, various anesthetics have been tried, and

the best results have been obtained using intravenous anesthesia with evipal or pentothal sodium. Evipal is the better of the two for tonsillectomy operations as it causes less respiratory depression. A 5 per cent. solution of evipal is injected slowly, preferably in one of the arm veins; the respiration and degree of relaxation are carefully watched; if respiration becomes too shallow, administration of the evipal is temporarily stopped; if a greater degree of respiratory depression should develop, oxygen should be administered. The average dose required for children has been found to be somewhat higher per unit of body weight than for adults; in the authors' series the average dose used was 22.5 mg. per kilo, the largest dose 37 mg. per kilo. This method of intravenous anesthesia has been employed for the tonsillectomy operation in 22 children with an average age of 8.9 years, the ages ranging from three to sixteen years. Nineteen of these patients had pulmonary tuberculosis, 2 unresolved pneumonia, and one bronchiectasis—all contraindicating the use of intratracheal anesthesia. In all these cases the operation was done easily and rapidly and the patient was returned to the ward in good condition. As a rule the patients were moderately restless; this can be controlled by a small dose of morphine; in recent cases morphine given pre-operatively has been found to be advantageous in controlling this postoperative restlessness. There was little, if any, vomiting and the cough reflex was always present; by evening, *i.e.*, ten hours after operation, all the children felt well, except for the soreness of the throat. There were 2 cases of postoperative bleeding in this series, easily controlled. The authors do not recommend this method of anesthesia instead of other methods for all children, but for a selected type of case, such as those reported, they find it definitely advantageous.

COMMENT

We have no doubt that evipal is an excellent anesthetic in the types of cases mentioned in this article. We have had no experience with it but have had considerable experience with avertin given by rectum. As a matter of fact, avertin is an excellent anesthetic in almost all operative procedures in children where general anesthesia is contraindicated. We particularly suggest it in children who have a tendency toward an enlarged thymus.

H. H.

Cancer of the Larynx

H. B. ORTON *(Archives of Otolaryngology, 28:153, August, 1938)* presents a review of 102 cases of cancer of the larynx in which operation was done. Ninety-one of the patients were men, only 11 women. There were 11 patients under forty years of age, the youngest twenty-five years of age; the largest number of cases occurred in the sixth and seventh decades of life among the male patients. No definite etiological factor could be found in the history of these cases. The cancer originated in the interior of the larynx in 77 cases in this series, with typical involvement of the vocal cords in 62 cases; 15 were subglottic. There were in addition 25 cases of extrinsic cancer. The subglottic growths show a greater tendency to early local metastases than chordal cancer. The most frequent symptom in this series was hoarseness (89 cases); any hoarseness persisting more than a few weeks in an adult is an indication for careful examination of the larynx; local discomfort with the constant desire to clear the throat and cough were noted in 59 cases; 45 patients complained of pain; 25 of difficulty in swallowing and 29 of dyspnea on moderate exertion. In 39 cases loss of weight was noted by the patient, before the cancer was far advanced. Diagnosis of cancer of the larynx depends on laryngologic examination with biopsy in addition to a careful study of the clinical history and the symptoms and physical signs. In 8 cases diagnosis of a "true chordal cancer" was made at such an early stage that laryngofissure was done; one of these patients died within three weeks after the operation of coronary disease; one showed recurrence; 6 are living and well, 4 of them ten years or more after operation. Laryngectomy was done in 94 patients; of this group, 5 died within three weeks after operation; 23 had recurrences; 9 have since died from other causes, without signs of recurrence; 57 are living and well, 22 of them five years and more after operation. Combining the results of the 8 cases of laryngofissure and the 94 cases of laryngectomy, there

are 63 patients living and well, and 9 deaths from other causes—or 72 successful results. The author notes that he cannot agree that laryngectomy is a mutilating operation; his laryngectomized patients are not despondent, and get "a great deal out of life."

COMMENT

We wish to congratulate Dr. Orton on the excellent results he has obtained in his cases of carcinoma of the larnyx. One must note the fact that the most frequent symptom was hoarseness, and again we wish to emphasize the importance of a thorough local examination in all adults who have had any hoarseness or aphonia lasting over any length of time. Although some men feel that the excision of a small growth can be accomplished through the direct laryngoscope, we agree with Dr. Orton that a laryngofissure operation is preferable.

H. H.

+ Otology +

Types of Deafness

G. E. SHAMBAUGH, Jr., *(Annals of Otology, Rhinology and Laryngology, 47:636, September, 1938)* notes that it is important to distinguish curable from incurable types of deafness, and that this differentiation depends largely upon hearing tests. "Secretory" otitis media, which is a curable form of deafness, can be distinguished from otosclerosis by means of hearing tests. The author has found that in otosclerosis with fixation of the stapes, there is a pronounced loss of hearing for the low tones, but hearing for the very high tones is almost normal. But in cases of secretory otitis media with fluid in the middle ear, the loss of hearing for high tones is as great as for the low tones. This is not due to inner ear involvement as shown by the fact that following evacuation of the fluid by paracentesis and inflation, normal hearing is restored for all tones. Another curable disease of the ear is exudative labyrinthitis, first described two years ago. The characteristic finding by hearing tests in this condition is diplacusis—where a given tone is heard at a different pitch in the two ears; there is usually a "low tone nerve deafness"; and repeated attacks of vertigo occur. Other characteristics of this type of deafness are unilateral involvement as a rule, tendency to recurrences, tendency of the hearing to fluctuate, and an apparent relation to focal infection. These characteristics are closely similar to those of iritis; and the author is of the opinion that the pathological changes are very similar to those of iritis, *i.e.*, cells and inflammatory exudate in the labyrinth. The condition can usually be cleared up by effective treatment of the focus of infection—not infrequently found in the tonsils or sinuses.

COMMENT

We have always been of the opinion that the majority of cases of deafness can be improved if the otologist will conduct the right method of treatment and the patient will come frequently enough for treatment to make it worth while. Unfortunately, too many cases of deafness are diagnosed as otosclerosis. The Eustachian tube is at fault in many cases. We are interested in the thought that certain types of deafness are similar to the recurrent attacks of iritis. In these cases the focus of infection must be found and eradicated.

H. H.

Hearing Aids and Otologists' Audiograms

A. A. HAYDEN *(Journal of the American Medical Association, 111:592, Aug. 13, 1938)* notes that the old methods of testing hearing do not supply the necessary information for "prescribing" hearing aids for the deaf. Hearing must be measured more exactly by the use of one of the new tone audiometers; the author has tested four of the five audiometers now available and finds the clinical observations with these different instruments are "quite consistent." With any of them hearing can be measured more exactly and also more rapidly than with the older methods. The audiogram obtained is also the best method of recording the hearing loss in each case, which is of great value not only in diagnosis, but also in the "fitting" of hearing aids and for medicolegal purposes. Three hundred audiograms made by various otologists have been studied for the prescribing of hearing aids to their patients. In the trial of hearing aids by these patients it was found that 92 out of the first 100, all tested by one man, preferred the trial

hearing aid that was based on the otologist's audiogram prescription. In the second 200 patients, tested by various otologists, 146 selected the aid based on the prescription and the remainder did not vary greatly from it. In this work, it has been found that if the difference in air conduction is greater than 20 decibels and in bone conduction less than 10 decibels, the hearing aid should be fitted to the ear with the greater loss in air conduction. But if the difference in air conduction is less than 20 decibels and in bone conduction greater than 10 decibels, the hearing aid should be fitted to the ear with the smaller loss of bone conduction, to obtain the most improvement in hearing.

COMMENT

The importance of this article rests on the fact that at last there is some cooperation between the otologist and the manufacturers of hearing aids. No doubt the time will come, probably in the near future, when the specialist will be able to measure a patient for a hearing device as accurately as the eye specialist can examine for glasses. Unfortunately, audiometers are not standardized. We believe that action to bring about standardization is in process at the present time. At a recent meeting of the Academy of Ophthalmology and Otolaryngology, the author and Dr. Newhart quite definitely stated that there are only about four types of hearing devices on the market at the present time which are so accurately made that suitable selective instruments can be prescribed for individual patients.

H. H.

Grafts in the Round Window in Chronic Progressive Deafness

W. HUGHSON *(Laryngoscope, 48:533, August, 1938)* describes an operation on the round window employed in the treatment of chronic progressive deafness. Before operation is attempted, a thorough diagnostic study is made, consisting of repeated hearing tests of air and bone conduction, loudness balance, fatigue tests and careful analysis of the audiograms for different frequencies. Since the loss of "serviceable hearing" is of greatest significance, the frequency range of 256 to 4,096 cycles is most important. A general clinical survey of the patient must also be made, as in some cases the successful treatment of "remote disorders" results in definite improvement in hearing. The operation described by the author consists in the placing of a tissue graft in the round window; the tissue is obtained through a small incision made immediately behind the base of the ear; fascia alone, fat and fascia, or periosteum have been used. In the cases operated the graft has never failed to take. This operation has been done on 25 cases; in all of these the drum membrane was thickened and retracted to some degree, but not sufficient to account entirely for the loss of hearing in many cases. In 90 per cent. of 18 cases followed up postoperatively, hearing was improved at least 10 decibels; this improvement has been maintained for the period of observation, varying from three to twenty months. In 60 per cent. of cases, the hearing in the poorer ear which was operated has reached or surpassed that in the better ear; in 50 per cent. of cases the deafness in the better ear (not operated) has increased, while the hearing in the operated ear remained stationary or continued to improve.

COMMENT

Although it is of interest to read of a new operative procedure, particularly when it is as simple as the one mentioned in this article, we question whether any operation of this kind will give a permanent result. Some twenty-odd years ago we tried similar methods but found that adhesive processes took place in the middle ear and around the oval and round windows which made the condition just as bad or even worse than it was before the operation.

H. H.

A New Surgical Technique In Otosclerosis

JULIUS LEMPERT *(Archives of Otolaryngology, 28:42, July, 1938)* describes a new surgical technique for obtaining a permanently open fistula of the labyrinth in the treatment of otosclerosis. The operative technique is described in detail. The essential features are: An endaural, antauricular approach to the temporal bone; the construction of a trough shaped fenestra in the bony capsule of the external semicircular canal; replacement of the bone removed by a tympanomeatal cutaneous membrane inserted into the fenestra and

maintained in direct contact with the perilymph; decompression of the dura in the temporal lobe to arrest progressive labyrinthine venous stasis; performance of the entire operation in one stage. This operation is indicated in cases of otosclerosis with clinical evidence of fixation of the stapes and loss of hearing of not less than 40 per cent. (with loss of "practical" hearing) and not more than 60 per cent.; provided that bone conduction is normal, or is reduced not more than 30 decibels for the 512, 1024 and 2048 frequencies; that there is no suppuration in the middle ear, a normal, translucent tympanic membrane, and a healthy cutaneous lining of the bony walls of the external auditory canal; and that the patient's general health is good. The author reports 23 cases of otosclerosis operated by this method; in 19 of these cases "a good practical improvement in hearing" was obtained and has been maintained. In 4 cases the operation was done in spite of poor bone conduction, and no improvement in hearing was obtained. In all but one of the 23 patients, the fistula has remained open, as shown by the fistula test; in this one case it closed within three weeks after operation. The author's experience leads him to conclude that when the fistula does close, regeneration of bone takes place promptly, and that a fistula that does not show signs of beginning regeneration of bone after two months will remain open permanently.

COMMENT

As in the case of all new operative procedures, one feels that there is some hope, particularly when reports founded upon work done by French operators indicate that permanent improvement of hearing has resulted from an operation on the labyrinth. Regardless of the fact that the author reports such excellent results, we wish to be rather conservative and also wish to point out the fact that he has not followed his cases for a sufficient length of time to prove anything. In the one or two instances where we have come in contact with patients upon whom he has operated, we have not been satisfied that this procedure has resulted in any good and unfortunately some of these patients are suffering from symptoms so distressing that they rather wish they had not had the operation performed.

H. H.

Labyrinthine Destruction in the Treatment of Vertigo by Alcohol Injections

A. J. WRIGHT (*Journal of Laryngology and Otology, 53:594, September, 1938*) from his study of aural vertigo is convinced that labyrinthine destruction or division of the eighth nerve is indicated in only a few cases; most cases can be treated by removal of foci of infection. The chief indication for labyrinthine destruction or nerve division is labyrinthine disturbance resulting from middle-ear suppuration, especially after radical operation; labyrinthine destruction may also be the preferable procedure in which adequate eradication of the foci of infection is difficult or involves extensive surgical procedures. The author describes his technique for labyrinthine destruction by the injection of alcohol through the oval window. He considers that this method involves "minimum trauma and risk to the patient." The operation is done under general anesthesia, but only a light anesthesia of a few minutes duration is necessary, so that the procedure is suitable for "frail and aged patients." The position of the stapes is defined approximately by various landmarks (as described in detail), and "actually located" by making firm pressure with the needle in one or more positions until a sensation is felt as of passing through a thin layer of bone, and then moving forward about 2 mm. This sensation, "with a little experience," is very definite. Only 1 minim of absolute alcohol colored with methylene blue is injected. If the injection does not give the desired result, it can be repeated after a week or two. The author has treated some 15 cases by the method with good results in relief of vertigo. In the first case operated, a facial palsy resulted which has persisted; this was due to the use of too large an amount of alcohol; the vertigo in this case is completely relieved. A temporary facial palsy occurred in one other case, but cleared up completely. No other undesirable effects have been observed. With this method the alcohol is injected directly into the part of the labyrinth that it is necessary to destroy—the vestibule. The method requires some training on the part of the surgeon, but with the technique and apparatus described the author has not found it difficult.

COMMENT

Fortunately we do not see many cases of vertigo that are so severe that alcoholic injections are necessary. The author states that the operation is simple. Perhaps it is in his hands, but one should master the technic by experimenting upon cadavers before one tries it on human beings.

H. H.

Gynecology

Persistence of Gonococcal Infection in the Adnexa

W. E. STUDDIFORD and his associates at Bellevue Hospital, New York City, *(Surgery, Gynecology and Obstetrics, 67:176, August, 1938)* report a bacteriological study of the inflamed tubes and ovaries removed at operation from 24 patients with gonococcal infection of the adnexa. The disease was subacute or chronic in all cases, and most of the patients had been afebrile for at least two weeks. In 16 of the 24 cases positive cultures of gonococci were obtained from both pieces of tissue and exudate. The duration of the infection in these cases ranged from one month to ten years, the average being eighteen months; only one positive cervical culture was obtained in these cases. Pathological study showed marked structural changes in the tubes in all cases; 19 were classed as subacute salpingitis and 2 as acute exacerbations of chronic salpingitis, on the basis of the nature of the exudate. Three were classed as chronic salpingitis with little or no inflammatory reaction. In the cases of subacute salpingitis there were 13 positive and 6 negative cultures. Both the cases of acute exacerbation of chronic salpingitis gave positive cultures; and one of the 3 cases of chronic salpingitis. In one of the cases with positive cultures, the tube had been injected with turpentine; in another fever therapy had apparently cured the cervical infection. These findings indicate that, contrary to previous reports, the Fallopian tubes may be active foci of gonococcal infection for "long periods of time." Acute exacerbations of chronic salpingitis may be caused by "recrudescences" of residual infection rather than re-infection.

COMMENT

We have long taught that gonococcal infections were self-limited and that after a certain length of time (months or years, depending on the original site of infection) "a cure" will have taken place. In the adnexa, this idea was particularly true. The authors have proven, (conclusively to themselves) that this is not true, for in their series of 24 cases they were able to obtain positive evidence of latent gonorrhea from tissue removed at operation. These cases had had gonorrhea from 7 to 10 years previous to operation. These are interesting observations but need further verification before we change our ideas about the life-expectancy of the gonococcus.

H. B. M.

Artificial Fever Therapy and Sulfanilamide in the Treatment of Gonorrheal Infections of Women

L. M. RANDALL and his associates at the Mayo Clinic *(American Journal of Obstetrics and Gynecology, 36:230, August, 1938)* report the use of fever therapy in the treatment of 37 cases of gonorrheal infection in women with gonococci present in the smears from the cervix and urethra. In 31 cases a single ten-hour treatment in the artificial fever cabinet was given, and in 22 of these cases, additional local heat treatment was given. In 6 cases multiple artificial fever treatments were given. In 34 of the 37 cases, "consistently negative" cultures were obtained with this treatment. Sixteen patients with positive cultures from the cervix and urethra were treated with sulfanilamide given by mouth; 60 gr. (4 gm.) of the drug was given on the first day in four doses; 80 gr. on the next two days, then 40 to 60 gr. daily. Treatment is continued for nine to ten days, and longer if cultures remain positive. Consistently negative cultures were obtained in 15 of the 16 cases; the average total dose of the drug was 590 gr.; the largest total dose was 1350 gr. Most of the patients tolerated the drug well; but it must be given under careful medical supervision and discontinued if any serious symptoms or a significant anemia occurs. The authors are of the opinion that gonorrheal infections of the female genital tract should first be treated with sulfanilamide, if the drug can

be given "under the direction of a physician." In cases intractable to sulfanilamide alone, it should be combined with fever therapy.

COMMENT

Gonorrheal infections in women are notoriously elusive and difficult to eradicate. Any method or combination of methods, therefore, that will successfully cure these infections, is "good news". The authors have had so much experience with both fever therapy and sulfanilamide, either singly or in combination, that it seems reasonable to say that, at present, these forms of treatment are the best we possess.

H. B. M.

Supravaginal Hysterectomy

W. T. DANNREUTER *(American Journal of Surgery, 41:373, September, 1938)* reports results in 535 cases of supravaginal hysterectomy; in these cases after amputation of the corpus at the level desired, the cervical stump was reamed out so that most of the endocervix was removed, leaving "little more than a disc of cervical tissue in the vaginal vault." In this series there were 9 postoperative deaths, a mortality of 1.7 per cent. and postoperative complications in 60 cases, 11 per cent. A few patients had multiple complications. The most frequent complications were pulmonary (17 cases), and wound complications (13 cases). There was only one case of pulmonary embolism, although the operation was done with clamps and not with primary ligatures. Supravaginal hysterectomy is not indicated in cases with extensive cervical disease, any signs of malignant lesion or a potentially malignant lesion in the cervix. But in many cases a damaged cervix may be "reconverted to a healthy state" before operation. Where this operation is done on proper indications, the author finds no higher incidence of carcinoma of the cervix than in women who have never been operated upon. The author favors conservation of the cervix wherever possible, not because of "any material difference in the morbidity and mortality of complete and supravaginal hysterectomy," but on account of the "sexual impairment," dyspareunia and consequent marital difficulties that almost invariably follow hysterectomy with removal of the cervix. The author is of the opinion the vaginal hystectomy, total abdominal hysterectomy and the supravaginal operation, each has its indications, and the operation to be done should be selected in each case on the basis of these indications. But for benign conditions in sexually active women, he prefers the supravaginal method unless there is some definite contra-indication in the condition of the cervix.

COMMENT

All types of hysterectomy, i.e., vaginal, total abdominal, supracervical, have their indications. One man or one clinic is apt to favor one type of operation to virtually the exclusion of all other types, which is probably not to be "frowned upon" too much because the technic of the favored operation is highly developed and the experience of the operator more fully matured, and therefore the operation has a wider application. After all is said and done, all types of hysterectomy have their indications and the operation to be done should be selected in each case on the basis of such indications.

H. B. M.

Causes of Vaginal Bleeding and the Histology of the Endometrium after the Menopause

H. C. TAYLOR, Jr., and R. MILLER *(American Journal of Obstetrics and Gynecology, 36:22, July 1938)* report a study of 406 cases admitted to the Roosevelt Hospital, New York City, because of vaginal bleeding after the menopause. In 259, or 63.3 per cent of these cases, some form of malignant tumor was found to be the cause of the bleeding. Carcinoma of the cervix occurred in 125, and carcinoma of the corpus in 101 cases; only 3 of the patients with carcinoma of the corpus were under fifty years of age. Myosarcoma of the uterus occurred in 5 cases; there were 8 cases of ovarian carcinoma and 4 cases of granulosa cell tumor of the ovary; 9 cases of carcinoma of the vulva. In 67 cases, or 17 per cent., of the series, benign tumors of the uterus and ovaries were the chief cause of the bleeding; fibromyoma of the uterus was the most frequent benign tumor, occurring in 36 cases, in 8 of which there was an associated benign ovarian tumor. The frequency of fibroid tumors of the uterus

in this series, the authors note, is "contrary to the belief widely held that these tumors cease to cause trouble after the cessation of the menses." In 2 cases with typical cystic pseudomucinous tumors of the ovary, there was an associated hyperplasia of the endometrium. Inflammatory lesions, usually in the cervix or vagina, were the apparent cause of the bleeding in 46 cases, or 11 per cent. In the remaining 34 patients, about 8 per cent., no gross inflammatory lesions or tumors were found. In 7 of these cases the endometrium did not show the usual atrophy of the menopause, but resembled the interval phase of the normal endometrium, but the glands were less regular and often cystic, and some of the specimens suggested hyperplasia; in 3 cases in which less than a year had elapsed since the cessation of menstruation, a typical premenstrual endometrium was found. In 3 cases there was definite endometrial hyperplasia. Endometrial hyperplasia had also been found in 2 patients with pseudomucinous ovarian cysts, as noted, and in 4 with granulosa cell tumor of the ovary. The endometrial hyperplasia in the postmenopausal uterus, the authors note, may be "of a more neoplastic character than the hyperplasia of earlier years," and may be a precursor of cancer of the corpus.

COMMENT

All vaginal bleeding at, during or after the menopause should have a diagnosis as to the cause of such bleeding. Cancer must be ruled out in all cases. It is gratifying to have the authors state that fibroids do not always "dwindle away" after the menopause. Our experience teaches us that fibroids very frequently cause "plenty of trouble" after the menopause; e.g., bleeding, degenerative changes, occasional malignant changes, production of pelvic pain, etc.

We can endorse every statement made in this very instructive paper. Read it!

H. B. M.

Conization of the Cervix

N. F. MILLER and O. E. TODD *(Surgery, Gynecology and Obstetrics, 67:265, September, 1938)* have used the electrosurgical cutting and coagulation current for conization of the cervix in 899 cases. When the cutting current is "properly combined" with the coagulation current, the procedure is bloodless. While conization may be done as an office procedure, the authors prefer to hospitalize every patient for three to four days. After conization an iodoform wick is placed in the cervical canal except when a subtotal hysterectomy is to be done. This is removed when the patient is discharged, and she is directed to take a daily cleansing douche and to report for treatment at two week intervals. At each treatment the cervix is painted with an antiseptic solution and a sterile sound or hemostat is passed into the canal. Treatments are repeated until epithelization is complete, to prevent stricture. Conization is used to correct minor cervical disease and to prevent "remote complications" in women for whom subtotal hysterectomy is planned; to treat deep seated chronic infections of the cervical canal in women past the childbearing age; as a complete substitute for the Sturmdorf operation in cases where this operation would be indicated; to obtain adequate tissue for biopsy in cases where the original biopsy indicates possible malignancy; as a substitute for trachelorrhaphy in most cases and especially in elderly patients.

✚

COMMENT

Chronic infections of the cervix are probably the most common pathologic lesions that the gynecologist encounters. If this is true hospitalization for all cases in which conization is indicated is simply out of the queston. It is economically unreasonable. We do not believe, after 20 years of fairly extensive experience, that hospitalization for the proper treatment of minor cervical lesions is ever indicated. The operation of conization, as we understand it, was devised for the sole purpose of adequately treating infections—and other lesions—of the cervix without hospitalization. Furthermore, we emphatically deny that conization should ever take the place of the Sturmdorf operation. Of course, the high frequency current can be used for obtaining a biopsy; so can the scalpel or "punch" be used in the office without anesthesia. Conization of the cervix as a routine operation is an office procedure and if the lesion is so extensive that hospitalization is indicated then conization is not the operation of choice.

H. B. M.

Obstetrics

The Pelvic Joints During Pregnancy and Labor

D. J. THORP and W. E. FRAY *(Journal of the American Medical Association, 111:1162, Sept. 24, 1938)* in a previous roentgenological study of a small series of pregnant women found that there was not a sufficient relaxation of the pelvic joints in pregnancy to enlarge the pelvic girdle so that a "potentially difficult labor" would be converted into an uncomplicated labor. In this study, the authors have made a series of roentgenograms in pregnant women near term (the last two or three weeks of pregnancy) and again in the first stage of labor. Pelvigrams were made by the Thoms method; the second film made in the first stage of labor in each case was taken at the height of a uterine contraction after the first stage was "well advanced." For this film, the position of the patient, exposure time and all other factors were identical with those employed for the first pelvigram. Seventy-eight patients were studied; none of them showed any definite deviation from normal on the initial pelvigram. Of these 34, or 43.6 per cent., showed definite widening of the symphysis pubis in the first stage of labor, averaging 5 mm.; the maximum widening was 12 mm. in one case. No increase in the area of the superior strait was demonstrable as a result of this widening of the symphysis pubis. In 13 cases of separation of the symphysis, the infant was in the occiput posterior position, and rotation occurred spontaneously in 9 cases; in 4 cases manual aid (rotation) was required. In the cases in which rotation took place spontaneously, the widening of the symphysis was 7 mm. or more; in the cases requiring manual rotation, the widening averaged only 4 mm. In 6 cases of occiput posterior position in the 44 cases showing no widening of the symphysis, spontaneous rotation took place in only 2 instances. In all cases in which the pelvigram showed pubic widening greater than 3 mm., the labor was definitely shorter than in 44 cases in which there was no demonstrable widening; the average duration of the first stage in primiparae who showed such pubic widening was three hours less than in primiparae without widening. In 21 cases in the series, separation of the sacro-iliac joints was noted, but there was no evidence that this condition influenced the course of labor. Women who showed widening of the symphysis pubis had no pain or disability postpartum, but 3 of the women with widening of the sacro-iliac joints had definite disability.

COMMENT

There has never been sufficient evidence adduced to prove that "the relaxation of the pelvic joints during pregnancy and labor" is sufficient to enlarge the pelvis. Certainly the "springing apart" of the symphysis pubis, as shown by the authors during the second stage of labor, does allow for more room in the pelvis at the moment but has no permanent effect on the size of the pelvis. We have all demonstrated this fact many times in tedious, spontaneous and forceps deliveries. All sacro-iliac separations are painful and therefore pathologic, but do not have any influence on the course of labor.

H. B. M.

Estrin in the Urine of Normal and Toxemic Patients in the Last Trimester of Pregnancy

J. E. SAVAGE and his associates at the University of Maryland *(American Journal of Obstetrics and Gynecology, 36:39, July, 1938)* have previously reported the determination of estrin in the urine by a chemical method, in patients in the last trimester of pregnancy; and have found the estrin secretion to be lower in chronic nephritis complicating pregnancy and in pre-eclampsia than in normal pregnancy. In this report, they describe briefly a modified and shortened chemical procedure for the determination of estrin in the urine; with this method the test can be completed in four hours. In a further series of 6 normal cases of pregnancy, 26 cases of chronic nephritis complicating pregnancy and 26 cases of pre-eclampsia, this method was used for the determination of estrin in twenty-four hour specimens of urine. Estrin excretion expressed as ferric chloride numbers (F.N.) gave averages of 87.16 for the normal cases, 47.05 for the cases of

chronic nephritis, and 40.03 for the cases of pre-eclampsia. Thus the normal cases could be definitely distinguished from the toxemic cases on the basis of estrin excretion. Nine of the toxemic patients were given an injection of 10,000 international units of theelin intramuscularly on three successive days. No definite improvement in clinical symptoms was noted as a result of this measure; but a short average duration of labor was noted which may have been the result of the theelin therapy. The authors note that "the possible advantages of administering theelin to patients with decreasing estrin excretion before clinical manifestations of toxemia appear should certainly be kept in mind."

COMMENT

We are continuously striving for more information on the toxemias of pregnancy. Since we do not yet know the etiology of this pathologic state, this is as it should be. It is known that the estrin secretion during the last trimester of pregnancy is lower in the presence of chronic nephritis and pre-eclampsia than it is in a normal pregnancy. Therefore if theelin (estrin) be given in sufficient dosage to these patients at the very beginning of toxic manifestations it should ameliorate or prevent the toxemia. The authors gave this form of therapy to the already severely toxic pregnant patient and found no effects save perhaps a shorter and easier labor. We need more such investigations.

H. B. M.

Weight Changes and Toxemia of Late Pregnancy

R. S. SIDDALL and H. C. MACK *(American Journal of Obstetrics and Gynecology, 36:380, September, 1938)* report a study of the weight gains in 100 cases with various types of toxemia in the last four lunar months of pregnancy. The patients were weighed at the twenty-fourth, twenty-eighth, and thirty-second weeks, and after that every two weeks up to delivery. These records were compared with similar weight records for 624 normal pregnant women. It was found that the average gain of weight in this period in the toxemic cases was 17 pounds, and in normal women 15.7 pounds. In studying the weight records of the 100 individual women with toxemia, it was found that 61 gained at least twice the normal average in weight at one or more of the observation periods, while 39 showed no excessive gain. In 37 patients the excessive weight gain preceded definite signs of toxemia; in the others, it appeared with or later than these other symptoms. In about 45 per cent. of the normals, similar excessive weight gains were noted. Sudden or abrupt weight increase was somewhat more frequent in toxemic than in normal patients, but it "was far from the rule." The presence or absence of excessive weight gain could not be related to the type or the severity of the toxemia. The authors conclude that: "The occurrence of excessive weight gains in pregnancy would appear of doubtful significance in predicting impending toxemia and of secondary value at most, in the diagnosis of the actual disease."

COMMENT

While we can agree that excessive gain in weight during pregnancy need not necessarily give rise to a toxemia of late pregnancy, yet we firmly believe that such patients, everything else being equal, are much more apt to develop toxemia than the patient who has a normal gain in weight. The weight gain is not the sole etiologic factor but undoubtedly works synergistically with other factors to produce a toxemia. Our patients are not allowed to gain excessive weight and we think we have the absolute minimum of toxemias of late pregnancy. Try it.

H. B. M.

Pregnancy after Myomectomy

G. COTTE and P. MAGNIN *(Gynecologie et obstétrique, 38:5, July 1938)* report a study of the occurrence of pregnancy in women in whom a myomectomy had been done before the age of forty-one years. Of 39 such women who were married and did not admit using contraceptive measures, 6 had adnexal disease that would render pregnancy impossible or unlikely. Of the remaining 33 women, 10, or 30 per cent., had had one or more pregnancies since the operation. In 2 cases the pregnancy was terminated by abortion. In 8 cases the women were delivered of a normal child. Of these 8 women, 5 have had only one child since the myomectomy; 3 of these women had not had children before the operation although married for several years. Two of the 8 women have had two children since the operation, and one has had

three children. In most of the cases in which pregnancy has occurred after myomectomy, there has been an interval of at least two years between the operation and the pregnancy; hence it is probable that some of the authors' patients operated more recently will yet become pregnant. Pregnancy is also much more frequent in women operated before the age of thirty-five; thus it is in these younger women that myomectomy gives the best chance for future fertility.

COMMENT

Myomectomy is not an operation of choice with us, except in very special cases. When myomectomy is clearly indicated in a child-bearing woman we are very careful in the technic of the operation. The less trauma to the uterine musculature, the more perfect the hemostasis obtained, and the smoother the approximation of all suture lines, the better the uterus will "stand" the strain of subsequent pregnancy and labor. We have seen one case of rupture of the uterine scar following myomectomy.

Your commentator believes that although the majority of cases of pregnancy and labor after myomectomy follow the same course as those without myomectomy, he, nevertheless, must warn that there is always some danger of rupture through the scar. Remember this and "keep a better watch" over these patients.

H. B. M.

Sterilization of Obstetrical Patients

G. S. McCLELLAN and L. E. BURCH *(American Journal of Obstetrics and Gynecology, 36:249, August, 1938)* present a study of 100 obstetric cases in which sterilization was done in Vanderbilt University Hospital (Nashville, Tenn.) from October, 1925 to March, 1937. In 29 cases sterilization was done because of pulmonary tuberculosis and in 2 cases because of tuberculosis of the spine. In several of the tuberculous cases there were complicating conditions which rendered sterilization necessary, but active pulmonary tuberculosis was considered sufficient indication, especially for women who could not be relied upon to carry out contraceptive measures. The next most frequent indication for sterilization in this series was toxemia of pregnancy in 28 cases; 12 of these patients had been delivered by Cesarean section. Sterilization was done in 16 cases because of cardiac disease; and in 11 cases because of previous Cesarian section; in 10 of these cases the condition for which the section was done still persisted. In 8 cases the indication for sterilization was pelvic deformity; in 5 cases, abnormalities of the soft parts. In 3 cases the patient was sterilized because of social and economic conditions; and in 5 cases at the patients' own request. In the earlier years sterilization was done by the abdominal route, but more recently the vaginal method has been preferred when the patient was delivered by the vaginal route. The vaginal method has definite advantages; it is easily carried out with least discomfort to the patient, and with any type of anesthesia including local anesthesia combined with analgesia. The danger of infection is less since the greater peritoneal cavity is not opened; and the period of hospitalization necessary is short. Various techniques for the operation on the tubes have been employed with either method of approach; recently the Pomeroy-Lull technique has been most frequently used. Of this series of 100 patients, 89 have been followed up, and none has become pregnant; 5 or 6 of these have been recently operated; 6 patients have died; and 5 could not be traced. Sterilization of an obstetric patient should be done only after careful consideration of congenital or acquired defects of the pelvic structure, pathological lesions of "organs or systems of organs" and abnormal mental states. "Social and economic factors should also be considered."

COMMENT

In recent years, request for sterilization of the obstetric patient has become much more frequent than in former years. There are many reasons for this state of affairs—some valid, some invalid. Hence we physicians must of necessity become more "sterilization conscious". Every case must be individualized and the reason or reasons for sterilization carefully considered in each particular case. Economic and/or social conditions may, not infrequently, become valid reasons for "no more children". Here as always integrity and reason must be mixed with sound judgment when the question of sterilization is up for consideration.

H.B.M.

MEDICAL

MATERNAL MORTALITY

As long as there is a preventable maternal mortality rate, whether attributable to the medical profession or to the laity, it is our duty to continue to plan and work toward its reduction.—Frederick C. Holden, M. D. In *Journal of the Medical Society of New Jersey*, April, 1938.

THE NEED OF CO-ORDINATED EFFORTS IN COMBATING CANCER

I sometimes liken the rise of mankind from the primordial ooze to the scaffold which two painters are raising up the side of a building. If only the ropes on one side are pulled, you know what happens to the paint and the painters. The ropes must be pulled equally. Through increased measures in public health, such as sanitation and preventive procedures, many previous causes of death have been removed; but the old man with the scythe is inexorable and will get you sooner or later. What in the long run does it amount to if we save someone dying of pneumonia or tuberculosis and so but preserve him to die a more horrible death with cancer a few years later —William G. Herrman. In *Journal of the Medical Society of New Jersey*, April, 1938.

ULCERATIVE ENTERO-COLITIS IN TUBERCULOSIS

In recent years great stress has been placed on the study of ulcerative entero-colitis by gastro-enterologists, proctologists, abdominal surgeons, and parasitologists. Their interest, however, has been confined to chronic non-specific ulcerative colitis, bacillary dysentery, amebic dysentery, and regional ileitis. Because of the extremely interesting clinical, laboratory and therapeutic problems these conditions present, there has been a tendency to forget the existence of a form of chronic ulcerative entero-colitis which is present in a greater proportion of the population than all the other colitities combined. I speak of *tuberculous entero-colitis*. Interest of medical workers in this disease has been somewhat lax, in part perhaps because of the striking and dramatic features manifested by the primary process in the lungs. Furthermore, the existence of tuberculous entero-colitis without the manifestation of subjective symptoms in many cases obscures its early diagnosis.—Emil Granet, M.D., and G. G. Ornstein, M. D. In *Journal of the Medical Society of New Jersey*, April, 1938.

EXPERIMENTAL POLIOMYELITIS BY TONSILLOPHARYNGEAL ROUTE

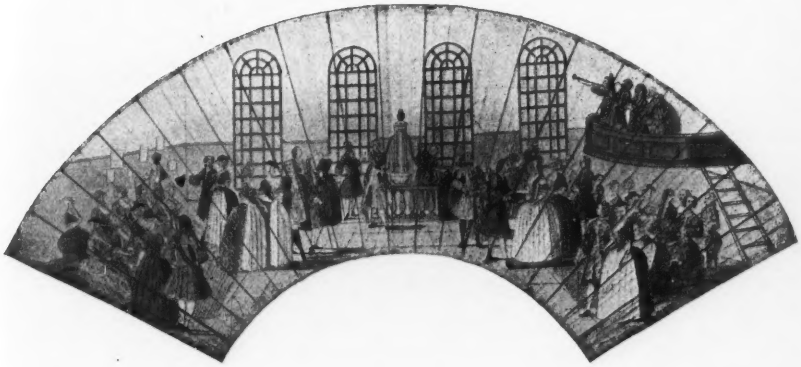
The purpose of this communication by ALBERT B. SABIN, New York *(Journal A. M. A.*, Aug. 13, 1938), is to present evidence (1) that the tonsillopharyngeal region is more highly sensitive to injections of poliomyelitis virus than are certain other regions of the body (e. g. the abdominal cutaneous or subcutaneous tissues) and (2) that the disease which results from infection by the tonsillopharyngeal route is, with few exceptions bulbar or bulphospinal in type and different in its clinical course from that which follows nasal instillation of the virus.

TUBERCULOSIS

The white race appears to be less susceptible to the ravages of tuberculosis than the darker races. This is probably due to the fact that this race has been infected over a long period of time and has developed a certain amount of resistance or immunity to the disease. It has been noted that when tuberculosis appears in a region where it has not been previously, the morbidity and mortality are frightful. This has been observed in the Indians in this country.

There is a difference in incidence of tuberculous infection in the cities and in the rural sections. The reason here is apparent. However, with easier modes of travel there is not as much difference as there was several years ago. In the crowded, poorer sections of the larger cities the incidence of infection is higher than in other sections. This is due to crowding and lack of proper food, fresh air, etc.—E. C. Edwards, M.D. In *Tri-State Medical Journal*, April, 1938.

Bath



✚ A contemporary drawing for a fan is of the eighteenth century town of Bath, a famous health resort in the West of England, renowned for the reputed qualities of its hot springs and the supposedly curative properties of the waters.

A glamorous phase of medical history

Medical Book News

• All books for review and communications concerning Book News should be addressed to the Editor of this department, 1313 Bedford Avenue, Brooklyn, New York.

Edited by Alfred E. Shipley, M.D., Dr. P.H.

Colonic Therapy

CHRONIC INTESTINAL TOXEMIA AND ITS TREATMENT. With Special Reference to Colonic Therapy. By James W. Wiltsie, M D. Baltimore. William Wood & Company, [c. 1938]. 268 pages. 12mo. Cloth, $3.00.

This little book differs from most works on the subject in not attempting to prove that there is such a condition as the title suggests, but in assuming that others have proved it. The chapter on anatomy and normal physiology of the colon is excellent. The description of different types of colonic irrigation and the apparatus therefor is instructive, even though we may not be in favor of the use of this modality. The chapter on "Diagnosis" is brief, but it covers the whole realm of physical and laboratory diagnosis in a superficial way, the conclusion being that, as "intestinal toxemia is the commonest disorder of the human being," no matter what is the matter with the patient this "toxemia" should be treated. The treatment as described consists essentially of some form of colonic irrigation, although, unlike most users of this type of treatment, the author, a physician, recognizes a number of contraindications. Should these be carefully studied, it will be seen that the author is really not such a rabid advocate of colon irrigation as a superficial perusal of his case reports might indicate, and we believe that the paragraph on "Contraindications" is the most valuable contribution in the whole work.

A. F. R. ANDRESEN.

Carl A. von Basedow
1799 - 1854

Classical Quotations

• *Madame F. felt herself very exhausted, suffered from an obstinate diarrhea, had night sweats, lost a great deal of weight; at which time the eyeballs began to protrude from the* Orbita. *The patient complained of shortness of breath; she had a very rapid, small pulse . . . a resounding heart beat, she could not hold her hand still, spoke with striking rapidity, and she liked to seat herself (because she always felt burning hot) with naked breasts and arms, in a cold draft. She showed unnatural excitement and carelessness about her condition . . . In the neck there appeared a strumous swelling of the thyroid gland; the area of pulsation of the heart was now broadened, pointing to enlargement, there was a sawing sound audible in the carotids, the pulse was more frequent and smaller, the hastiness of speech and the unnatural excitement of the patient still more increased, night sweats, very offensive; urine scanty and red and, considering the continued diarrhea, the appetite was always too strong. As far as the eyes were concerned, they were pushed out so far that one could see below and above the* Cornea, *the* Albuginea, *three lines wide; the eyelids were pushed wide from one another; could not be closed with every effort. The patient slept with eyes entirely open.*

Carl A. von Basedow. *Wochenschrift für die gesammte Heilkunde*, Berlin, March 28, 1840.

The Treatment of Alcoholism

ALCOHOL. One Man's Meat. By Edward A. Strecker, M.D., and Francis T. Chambers, Jr. New York, The Macmillan Company, [c. 1938]. 230 pages. 8vo. Cloth, $2.50.

A psychiatrist in the forefront of scientific and educational standards has here joined a lay therapist in a household exposition of what every man knows about alcohol. The book should be in family libraries because they will understand it and get a complete resume of traditional alcohol-fighting on a medical basis, together with an up-to-date explanation of commoner psychotherapeutic treatment by suggestion, relaxation and character rebuilding. There is a fairly complete inclusion of later scientific data on the clinical and physiological effects of the poison. The address to laymen is accentu-

ated by the lack of emphasis on the dynamic psychological role of alcohol as elicited by detailed psychoanalytical studies of alcoholics. The treatment here outlined as relaxation and rebuilding is an outgrowth of Peabody's work and antecedents. While it seeks to withdraw the patient from the "escape" psychology understood by all, it fails to recognize the dynamic sources of the escape and quasi-suicide in the deeper roots of the oedipus conflicts and family relationships.

SAM PARKER.

Another Viewpoint on Preventive Medicine

CAUSE AND PREVENTION OF DISEASE. By William H. Perkins, M.D. Philadelphia, Lea & Febiger, [c. 1938]. 713 pages. 8vo. Cloth, $7.50.

In the past two or three years, several new books on Preventive Medicine have been published and the approach to the subject in practically every instance has been from a different angle.

The book under review is no exception to this rule. Doctor Perkins puts his philosophy of prevention in this single phrase, "To oppose or intercept a cause is to prevent or dissipate its effects."

The author stresses the fact "that man is just as much a process as a particle," in consequence of which man is constantly adjusting himself to his environment. On this basis, disease prevention is discussed in several chapters of this volume from the standpoint of the natural body processes and the defense mechanism set up in the human organism against exogenous invasion.

At the same time, the importance of inherited factors resulting in disease are recognized, as well as nutritional defects, either natural or acquired, and defense measures against these conditions discussed.

Further, those environmental defenses of a communal nature that man has devised, such as water purification, food supply control, defense against living animal hosts and the like, are outlined in a satisfactory way.

It is not so much the subject matter itself, but the method of arrangement for the consideration of the reader, that makes this book worth while.

ALFRED E. SHIPLEY.

Visceral Neurology

SYMPTOMS OF VISCERAL DISEASE. A Study of the Vegetative Nervous System in Its Relationship to Clinical Medicine. By Francis M. Pottenger, M.D. Fifth edition. St. Louis, The C. V. Mosby Company, [c. 1938]. 442 pages, illustrated. 8vo. Cloth, $5.00.

The 5th edition of this valuable book again stresses the importance of the vegetative nervous system in its relation to everyday life. Many chapters have been revised and enlarged to keep abreast with new lines of study of physiologic medicine. An additional chapter describes the vegetative centers in the brain and cord; and visceral pain is dealt with in a separate chapter.

More space is given to the endocrine glands, and their relationship to bodily function is stressed. However, the alloted space is entirely inadequate, especially since the author admits that visceral neurology and endocrinology are inseparable.

Again the author rightly emphasizes the importance of studying the patient rather than the disease per se.

The book should be in the library of every practitioner.

JOSEPH L. ABRAMSON.

A Pioneer in Mental Diseases

WILLIAM ALANSON WHITE THE AUTOBIOGRAPHY OF A PURPOSE. By William A. White, M.D., Garden City, Doubleday, Doran & Company, Inc., [c. 1938]. 293 pages. 8vo. Cloth, $3.00.

Dr. White, for thirty years at the head of St. Elizabeth, government hospital for the insane at Washington, D. C., finished his autobiography just one year before his death. He chose as a subtitle for his work, *The Autobiography of a Purpose*, that purpose being the humanitarian treatment of the mentally ill and the doing of everything within his power

to further their welfare. Early in his life he formed the idea that every action of a patient was due to some fixed law, that when a patient was disturbed an effort should be made to find out why he was disturbed. He believed that it was extremely important to preserve the personality of a patient just as far as possible. He carried out this idea to the extent of instituting a beauty parlor in the hospital, and instead of compelling women to go about in drab, ill-fitting wrappers or dresses, he permitted them to pick out their own materials and even to make their own dresses if they were able to do so. He was greatly opposed to capital punishment, and while he appeared in many notable criminal trials as an expert, it was always on the side of the defendant. He consistently refused to appear for the prosecution because he believed that the physician who testified as an expert for that side of a case was in an anomalous position; that the function of the physician should always be to salvage human beings, but not to destroy them.

In the preface of the book, Dr. White calls attention to the value of the mental hospital for the internist because he can study interesting cases over a long period of time; he believed that mental hospitals should be located in close proximity to general hospitals for teaching purposes. An interesting sidelight upon Dr. White's character is shown by his own estimation of the traits upon which the success of his career in his chosen field depended. He lists these traits as industry, curiosity and perseverance. He cites as an example of his perseverance that he made it a rule of his life never to leave a book unfinished that he had once begun. Doubtless many people would feel that perseverance carried to this extreme might result in much wasted time and energy.

White was graduated from L.I.C.H., in 1891; his chapter dealing with the medical school of that day will be of especial interest to alumni of the period of "Jarvy" Wight, Skene, and "Billy" who acted as host to his silent guests in the dissecting room.

Dr. White tells the story of his life work simply and clearly; he worked hard and had high ideals; he undoubtedly played a large part in the advance of psychiatry which took place in this country during his lifetime, and is especially to be remembered for his efforts to make the existence of the mental patient more tolerable.

F. C. EASTMAN.

Injection Therapy of Varicosities

INJECTION TREATMENT OF VARICOSE VEINS AND HEMORRHOIDS. By H. O. McPheeters, M.D. and James K. Anderson, M.D. Philadelphia, F. A. Davis Company, [c. 1938]. 315 pages, illustrated. 8vo. Cloth, $4.50.

This volume comprises two monographs dealing with the injection treatment of varicose veins and internal hemorrhoids. It is replete with information from the theoretical consideration of the cause of varicosities to a minutiae of detail for selecting and treating these diseases with indication and counterindication, complication and mortality. The indications for surgical treatment are also carefully outlined along with the selection of those types for combined surgery and injections. This section is adequately illustrated and describes the authors' technique and results. Of special interest is the anatomy and treatment of "rocket" and "spider" bursts.

The chapters on injection treatments for internal hemorrhoids are most carefully presented. Enough illustrations are included to make this book the most practical of any on the subject. In brief, it condenses an insurmountable group of facts collected from the authors' extensive experiences and various other sources, as will be noted from the text and bibliography. The book is highly recommended to surgeons and to general practitioners who may elect to treat varicosities and internal hemorrhoids by injection treatment.

JOHN A. TIMM.

A Reference Text on Food Chemistry

THE CHEMICAL ANALYSIS OF FOODS AND FOOD PRODUCTS. By Morris B. Jacobs, Ph.D. New York, D. Van Nostrand Company, Inc., [c. 1938]. 537 pages, illustrated. 8vo. Cloth. $6.00.

This book should be of real value to anyone concerned with the more detailed aspects of food analysis, the detection of food adulterations, etc. It is a sound work, clearly and directly written.

The author states that his foremost objective is to give systematic coverage to the salient facts of chemical analysis of foods and food products, and to include certain of the newer aspects of food analysis such as the chemical assay of vitamins, the detection of improper pasteurization of milk, the homegenization of milk, the detection of gums, and methods for the detection of newer types of sophistication of foods. Another objective is the presentation of timely topics which belong in modern literature on the subject, on which information has heretofore been difficult to obtain.

The book is divided into chapters on such subjects as coloring matters, preservatives, and metals in foods, milk products, fats and oils, sugars and carbohydrates, jams, jellies and fruits, spices, flavors and condiments, nonalcoholic and alcoholic beverages, meats and meat products, etc. There is also a valuable section on the vitamins.

The text should be accepted as a complete, authoritative, and up-to-date work on the subject.

ETHEL PLOTZ BERMAN.

Trauma of Athletes

ATHLETIC INJURIES. Prevention, Diagnosis and Treatment. By Augustus Thorndike, Jr., M.D. Philadelphia, Lea & Febiger, [c. 1938]. 208 pages, illustrated. 8vo. Cloth, $3.00.

This volume is intimately concerned with an exposition of injuries that an athlete is liable to sustain in competitive sports, and while many athletic endeavors are attended by a certain element of physical risk, the game of football takes the greatest toll. The press undoubtedly overemphasizes the casualty list that this particular game extracts, but nevertheless the author's figures bear out the contention that it outranks practically all other sports in this respect. Coaches, trainers, and team surgeons have had for their aim, over these many years, a reduction of this hazard to a minimum. It is accomplished in the present day by a careful supervision of the prospective athlete from the time he enters until he leaves college. Minor injuries acquired in preparatory school are given particular attention, nutrition by dietetic control plays a large part in conditioning, and training itself is based upon muscle dynamics aimed toward the intelligent avoidance of stress and strain on the more unprotected parts of the body. To this end athletic equipment has undergone radical changes. The author is particularly qualified to speak authoritatively because of his long contact with athletes as a surgeon in the Department of Hygiene at Harvard University.

His method is couched in terse style, not too technical, and for that reason is very practical as a textbook for physical educators, trainers, and athletes themselves.

A reviewer after reading this volume is convinced that were an athlete cognizant of certain mechanisms by which injuries occur, and the practical application of early treatment, he would be less inclined to do or die for dear old blahblah to the detriment of his future usefulness to team and Alma Mater. As a book for physicians it is particularly interesting in so far as it gathers together in a small volume a mass of information that the average physician could not hope to acquire by even an extensive acquaintance with current literature, and by the same token it is often to the family doctor that the potential athlete, injured in preparatory school, comes for advice and counsel regarding just such lesions as the author so competently discusses, not only from a standpoint of diagnosis, but of treatment as well. The illustrations are excellently chosen and make it possible to include, within a short monograph, a wealth of material.

DONALD E. MCKENNA.

A Plea for an Adequate Diet

FOOD AND PHYSICAL FITNESS. By E. W. H. Cruickshank, M.D. Baltimore, William Wood and Company, [c. 1938]. 148 pages. 12mo. Cloth, $2.00.

This small book is the printed series of lectures given by the author at the University of Aberdeen during the session of 1936-37.

It is well written, full of enthusiasm, and some of the lectures are particularly strong. He pleads for logic in matters of diet, denounces the fads, and believes that good nutrition is a matter of education rather than economics. He advocates an optimal diet over fifty per cent in excess of the adequate.

The only negative criticism is that he

has not given enough emphasis to what an optimal diet menu for breakfast, lunch, tea and evening meal would be for a lay person with no previous knowledge of dietetics.

PAUL C. ESCHWEILER.

Report on Influenza Epidemic in England

A STUDY OF EPIDEMIC INFLUENZA: WITH SPECIAL REFERENCE TO THE 1936-7 EPIDEMIC. By C. H. Stuart-Harris, C. H. Andrewes and Wilson Smith. (Medical Research Council, Special Report Series, No. 228). New York, British Library of Information, [c. 1938]. 151 pages, illustrated. 8vo. Paper, 80c.

His Majesty's Stationery Office has printed another extremely valuable "green book," this one on epidemic influenza as it appeared in the Woolwich, Eastchurch, Chatham and Rugby School epidemics in 1936-37. This study is a most complete review of the clinical and laboratory features of the disease and is warmly recommended to all physicians.

ANDREW M. BABEY.

Developmental Psychology

EMBRYONIC DEVELOPMENT AND INDUCTION. By Hans Spemann. New Haven, Yale University Press, [c. 1938]. 401 pages, illustrated. 8vo. Cloth, $5.00.

This is a highly technical work on the physiology of development. As stated in the introduction much of the experimental work is directed towards establishing relationships between particular developmental processes and with external conditions.

After short chapters on the normal development of the amphibian egg up to the formation of the principal organs of the embryo and early experiments in developmental physiology, the author proceeds directly to the problem of induction. By induction is meant the effect of a given portion of an embryo in bringing about definite developmental changes in neighboring germ plasma. Many induction systems have been discovered and are fully discussed. Certain unusual experiments have resulted in the induction of secondary embryos and in abnormal twin forms. Chapters on the gradient theory and regional determination are also included.

The book is not intended for the general practitioner. It indicates, however, the great progress made in the field of developmental physiology, and should be of great value to the experimental biologist and embryologist.

ALEXANDER H. ROSENTHAL.

A Practical Guide for Diagnosis

WORKBOOK IN ELEMENTARY DIAGNOSIS FOR TEACHING CLINICAL HISTORY RECORDING AND PHYSICAL DIAGNOSIS. By Logan Clendening. St. Louis, The C. V. Mosby Company, [c. 1938]. 167 pages, illustrated. 4to. Cloth, $1.50.

This volume ought to serve a useful purpose in the teaching of elementary diagnosis. It is designed to encourage the formation of systematic habits in history taking and in the recording of physical signs. It should be equally helpful to the instructor because its use will insure a systematic and orderly course in physical diagnosis.

As the author states, it is intended to be elementary and it is. Under examination of the eyes, no mention is made of examination of the retina. Perhaps the use of the ophthalmoscope is too advanced for sophomores. In the section on irregularities of the heart it seems to the reviewer that the description of the arrythmias is so brief that the beginner will not get a clear conception of the underlying mechanisms involved. In the section on auscultation of the heart, the important maneuver of turning the patient into the left lateral position to bring out apical diastolic murmurs is not mentioned.

These comments are made to be helpful, and should not in any way detract from the value of this useful book.

E. P. MAYNARD, JR.

A New Proctology

ANUS, RECTUM, SIGMOID COLON. Diagnosis and Treatment. By Harry E. Bacon, M.D. Philadelphia, J. B. Lippincott Company, [c. 1938]. 855 pages, illustrated. 8vo. Cloth, $8.50.

This most practical and complete book on proctology is decidedly welcome. It is of the encyclopedic type, incorporating within its 855 pages not only the author's great store of knowledge gained from his vast clinical experience, but also a most comprehensive survey of the worthwhile and important views of specialists in this field throughout the world. The reader in search of the various views on any given subject relating to proctology will find them in this volume. Accepted, as well as lesser known procedures, are

dealt with in a simple but detailed manner. Although different views and methods are frequently outlined for a single condition, the author indicates his choice and the logic upon which it has been based. The relationship of proctologic diseases to general medicine is clearly presented. Inasmuch as the book is restricted to diseases of the anus, rectum, and sigmoid, it deals often with subjects which are but cursorily treated in textbooks of surgery.

The thoroughness with which the author has covered the literature is evidenced at the end of each of the twenty-four chapters where an exhaustive bibliography is appended.

The book is profusely illustrated with 487 drawings and photographs of armamentarium, diseased conditions, and procedures. There are thirty-two illuminating tables of differential diagnosis scattered throughout the book, beginning with the differential diagnosis of inflamed anal papillae, external thrombotic hemorrhoids, skin tags, condylomata lata (luetic), condylomata acuminata, epithelioma, anal esthiomene, thrombosed internal hemorrhoids, adenoma (rectal polyp), and carcinoma in Table I, and ending with the differential diagnosis of Hirschsprung's disease, rickets, and tuberculosis peritonitis in Table xxxii.

An awakening to the realization of the magnitude of the subject of proctology is in store for those who acquire this book. This work should prove of inestimable value to anyone interested in the subject of proctology. It is a most practical book for the student, general practitioner, general surgeon, and proctologist.

A. W. MARTIN MARINO.

New Approach to Dementia Praecox Therapy

THE PHARMACOLOGICAL SHOCK TREATMENT OF SCHIZOPHRENIA. By Dr. Manfred Sakel. Authorized translation by Joseph Wortis, M.D. Revised English edition. Washington, Nervous and Mental Disease Publishing Company, [c. 1938]. 136 pages, illustrated. 8vo. Cloth, $2.75.

Schizophrenia, better known as Dementia Praecox, is the most dreaded of all mental disorders. It has been regarded as a chronic and incurable progressive psychosis with little hope for its victim.

The past two years, however, has witnessed a decided change of attitude of physicians toward this disease because of the introduction of insulin and metrazol in its treatment. In fact, the results have been so strikingly good in so many cases that a spirit of optimism has pervaded the entire group of psychiatrists who treat such patients. The general practitioner is as yet unfamiliar with this method of treatment and the results obtained.

Dr. Sakel introduced this method by using insulin, producing shock. His method of treatment, the results obtained, and a general consideration of the problem form the basis of this book. It is a valuable contribution in that it is written by one who has introduced the method and has had the satisfaction of having his form of treatment accepted all over the world.

There is a foreword by Dr. Pötzl who is the head of the University Clinic for Neurology and Psychiatry of Vienna where Dr. Sakel first did his original work. The introduction by Dr. Lewis and the preface by Dr. Kennedy enhance the value of the book. The progressive physician will not be without it and the general practitioner will do well to read it. It is recommended because of its authoritative value.

IRVING J. SANDS.

Another Book by Dr. Majocchi

MORE OF MY LIFE. By Andrea Majocchi. New York, Knight Publishers, [c. 1938]. 308 pages. 8vo. Cloth, $2.50.

Dr. Andrea Majocchi is one of the outstanding surgeons of Italy. We regret that we are not acquainted with his scientific publications but, judging from his literary efforts, we feel that Dr. Majocchi has a real flare for writing and a fascinating way of dramatizing his experiences as a physician and surgeon. In 1937 he published a collection of autobiographical sketches under the title of *Life and Death.* This book was accorded such a favorable reception that the author was influenced to add this second volume of personal observations and experiences. While these two books are addressed to the laity, they may be read with pleasure and profit by all physicians. The chapter, "The Tragedy of Appendicitis," is made more impressive

by having the tragedy of delayed treatment occur in the family of one of his confreres. The chapter, "Sunset," tells the story of his surgical preceptor, who has been retired from the position of chief attending because he has reached the age of retirement—an interesting study in psychology. We believe a word of praise should be added for the fortunate selection of an excellent translator.

JOSEPH RAPHAEL.

A Crusader's Thesis Against Censorship

A CHALLENGE TO SEX CENSORS. By Theodore Schroeder. New York City, The Author, [c. 1938]. 157 pages. 8vo. Paper.

This thought-provoking little book is evidently a forerunner of a larger volume of propaganda. The writer is a well known lawyer and author who has dedicated his energies and activities for many years as a crusader against governmental censorship in all forms.

The thesis of the book is contained in the sentence "Obscenity resides exclusively not in the thing contemplated but in the mind of the contemplating person." Many pages are devoted to an analogy between obscenity and witchcraft in which it is his contention that both are a quality of the mind and are not inherent in a book, picture or situation.

One can't doubt his earnestness but one may question his logic. With our present day knowledge of psychology, especially of the Freudian school, it is not difficult to understand his statement that every feelingful accusation is an unconscious confession on the part of the accuser. Nor is it necessary for the author to fill page after page with interpretations of ecclesiastics and psychologists to prove his point.

As an explanation for lay people of well known psychological phenomena the book is well worth while. Some may be aroused to enthusiasm by his contentions. However, to physicians, especially to those who have some knowledge of psychological mechanisms, the volume is puerile and soon becomes boring. It smacks of absurdity when the author charges "Puritan censors with responsibility for the backwardness of the mental hygiene movement and consequently for many of our unhappy marriages; for all unwanted and spoiled children; for the mental unpreparedness which precedes and promotes every nervous collapse." All one can say is tommyrot!

JOSEPH L. ABRAMSON.

About Our Daily Contact with Poisons

POISONING THE PUBLIC. Daily Contacts with Toxic Materials as Civilization Marches On. By Russell C. Erb. Philadelphia, Dorrance & Company, [c. 1937]. 219 pages. 12mo. Cloth, $2.00.

Aside from accidental, suicidal and homicidal cases of poisoning, more familiar to physicians than laymen, modern civilization brings to us a more insidious slowly-acting type of poisoning the harmful potentialities of which are seldom realized by the unsuspecting public. Though for political, religious or social reasons poisoning was an art as far back as 4,500 B.C., we are today unknowingly ingesting, inhaling, or making contacts with substances that have a toxicological significance, producing a symptomatology which often taxes the diagnostic acumen of trained clinicians. Poisons that lurk in foods, beverages, in the atmosphere, plants, animals and metals are carefully considered in this excellent little book. The chapter on cosmetic poisons is especially good.

FRED SCHROEDER.

Soviet Medicine

SOCIALIZED MEDICINE IN THE SOVIET UNION. By Henry E. Sigerist, M.D. New York, W. W. Norton & Company, Inc., [c. 1937]. 378 pages, illustrated. 8vo. Cloth, $3.50.

Read the introduction to this book and you will recognize the language of the enthusiastic communist. In view of this attitude, one can understand how much the observations on Socialized Medicine, as recorded in the subject matter, have been influenced by the philosophy of the writer. One infers that the medical millennium is approaching rapidly in Soviet Russia.

On the last page of the text, the author says, "Things move fast in the Soviet Union." Perhaps too fast! Which recalls the words of the old Sage, "When God was in a hurry, He made the cabbage; but when He wanted something to endure, He made the slow growing oak."

This old world of ours with its millions of years as a background, cannot be reconstructed overnight.

ALFRED E. SHIPLEY.

Another Book on Infant Care

THE CARE AND FEEDING OF BABIES IN WARM CLIMATES. By Charles J. Bloom, M.D. New Orleans, Pelican Publishing Company, [c. 1937]. 358 pages, illustrated. 8vo. Cloth, $2.75.

This is a guide book on the care and feeding of infants written by a pediatrician with a background of extensive pediatric practice. It is a different type of book from that usually written for the use of mothers, or even nurses. The author is quite specific in the detailed instructions he gives, especially on the subject of infant feeding.

Chapters are also devoted to the baby's clothes and care, the nursery, temporary suggestions for the sick baby, practical medical procedures, first aid, and preventative immunization. There is a chapter called Helpful Information in which is included a variety of data on the composition of many baby foods, diets at different ages, tables giving food values in terms of calories, vitamins, minerals, acid and base forming qualities. A special chapter, The Baby's Cook Book contains 200 recipes, and another unique feature is a table giving the dosage of useful drugs.

This book contains quite a storehouse of useful and practical pediatric information, and as such should prove serviceable for the physician in practice. It appears that the author gives more technical information than is customary in a publication for use by the laity. Whether this is or is not desirable, where infant care is concerned, is an open question today. The book will surely be valuable to nurses as well as to others interested in the care of infants. The author's methods appear excellent and his opinions well balanced. By advocating so clearly the value of certified milk for infant feeding, he has performed a particularly commendable service to the public and to the profession.

JOSEPH C. REGAN.

A New Treatise on the Urogenital System

THE PRACTICE OF UROLOGY. By Leon Herman, M.D. Philadelphia, W. B. Saunders Company, [c. 1938]. 923 pages, illustrated. 8vo. Cloth, $10.00.

This is the first edition of a work by Dr. Herman that surely will be followed by many others. Your reviewer read the entire volume with his interest sustained to the last page.

Dr. Herman is a splendid clinician with long personal experience. He has presented his material with a viewpoint different from most urologic textbooks, and in a practical and workman-like manner, making it quickly available both to the practitioner and the specialist.

The entire volume is complete both in its subject matter and references, so that it is difficult to single out any chapters for special comment, but to our mind the section devoted to Gonococcal Infection is really worth careful study by every practitioner of medicine. This new textbook should be on all library shelves as a reference work.

FEDOR L. SENGER.

BOOKS RECEIVED *for review are promptly acknowledged in this column; we assume no other obligation in return for the courtesy of those sending us the same. In most cases, review notes will be promptly published shortly after acknowledgment of receipt has been made in this column.*

YOU CAN SLEEP WELL. The A B C's of Restful Sleep for the Average Person. By Edmund Jacobson, M. D. New York, Whittlesey House, [c. 1938]. 269 pages, illustrated. 8vo. Cloth, $2.00.

THE HANDICAP OF DEAFNESS. By Irene R. Ewing, M.Sc. and Alex. W. G. Ewing, M.A. New York, Longmans, Green and Company, [c. 1938]. 327 pages, illustrated. 8vo. Cloth, $5.40.

EXPERIENCE IN THE MANAGEMENT OF FRACTURES AND DISLOCATIONS. By The Staff of the Fracture Service of the Massachusetts General Hospital under the general editorship of Philip D. Wilson, M.D. Philadelphia, J. B. Lippincott Company, [c. 1938]. 1035 pages, illustrated. 4to. Cloth.

PRACTICAL MICROBIOLOGY AND PUBLIC HEALTH. For Students of Medicine, Public Health, and General Bacteriology. By William B. Sharp, M.D. St. Louis, The C. V. Mosby Company, [c. 1938]. 492 pages, illustrated. 8vo. Cloth, $4.50.

THE NEW-BORN INFANT. A Manual of Obstetrical Pediatrics. By Emerson L. Stone, M.D. Second edition. Philadelphia, Lea & Febiger, [c. 1938]. 291 pages. 8vo. Cloth, $3.00.

THE PSYCHOLOGY OF EARLY GROWTH INCLUDING NORMS OF INFANT BEHAVIOR AND A METHOD OF GENETIC ANALYSIS. By Arnold Gesell, M.D. and Helen Thompson, Ph.D. New York, The Macmillan Company, [c. 1938]. 290 pages. 4to. Cloth, $4.00.

THE NEW INTERNATIONAL CLINICS. Original Contributions: Clinics; and Evaluated Reviews of Current Advances in the Medical Arts. Edited by George M. Piersol, M.D. Volume III, New Series One. Philadelphia, J. B. Lippincott Company, [c. 1938]. 341 pages, illustrated. 8vo. Cloth, $3.00.

PROYECTO DE ORGANIZACION Y REGLAMENTACION DE LA TRANSFUSION DE SANGRE EN LA CIUDAD DE BUENOS AIRES (1). By Dr. Emilio S. Sammartino. Buenos Aires. A. Guidi Buffarini, [c. 1938]. 141 pages. Paper.

LABORATORY MANUAL OF HEMATOLOGIC TECHNIC. Including Interpretations. By Regena Cook Beck, M.D. Philadelphia, W. B. Saunders Company, [c. 1938]. 389 pages, illustrated. 8vo. Cloth, $4.00.

SURGICAL PATHOLOGY. By William Boyd, M.D. Fourth edition. Philadelphia, W. B. Saunders Company, [c. 1938]. 886 pages, illustrated. 8vo. Cloth, $10.00.

THE PRINCIPLES AND PRACTICE OF OBSTETRICS. By Joseph B. DeLee, M.D. Seventh edition. Philadelphia, W. B. Saunders Company, [c. 1938]. 1211 pages, illustrated. 4to. Cloth, $12.00.

DIE ERNÄHRUNG DER OLYMPISCHEN KÄMPFER IN VERGANGENHEIT UND GEGENWART. By Adolf Bickel. Berlin, Deutsche Verlagsgesellschaft M. B. H., [c. 1938]. 35 pages. 8vo. Paper, RM.1.

BABIES ARE HUMAN BEINGS. An Interpretation of Growth. By C. Anderson Aldrich, M.D. and Mary M. Aldrich. New York, The Macmillan Company, [c. 1938]. 128 pages, illustrated. 8vo. Cloth, $1.75.

I SWEAR BY APOLLO. A Life of Medical Adventure. By William E. Aughinbaugh, M.D. New York, Farrar & Rinehart, [c. 1938]. 420 pages. 8vo. Cloth, $3.00.

HAVE YOU HAD YOUR VITAMINS? By Harry N. Holmes, Ph.D. New York, Farrar & Rinehart, [c. 1938]. 60 pages, illustrated. 12mo. Cloth, $1.00.

A SYNOPSIS OF PHYSIOLOGY. By A. Rendle Short, M.D. and C. L. G. Pratt, M.D. Third edition. Baltimore, William Wood and Company, [c. 1938]. 325 pages, illustrated. 12mo. Cloth, $3.50.

THE MEDICAL APPLICATIONS OF THE SHORT WAVE CURRENT. By William Bierman, M.D. Baltimore, William Wood & Company, [c. 1938]. 379 pages, illustrated. 8vo. Cloth, $5.00.

BIOGRAPHY OF THE UNBORN. By Margaret S. Gilbert. Baltimore, The Williams & Wilkins Company, [c. 1938]. 132 pages, illustrated. 8vo. Cloth, $1.75.

TRIUMPH OVER PAIN. By René Fülöp-Miller. Translated by Eden and Cedar Paul. Indianapolis, Bobbs-Merrill Company, [c. 1938]. 438 pages, illustrated. 8vo. Cloth, $3.50.

DISEASES OF THE CHEST AND THE PRINCIPLES OF PHYSICAL DIAGNOSIS. By George W. Norris, M.D. and H. R. M. Landis, M.D. Sixth edition. Philadelphia, W. B. Saunders Company, [c. 1938]. 1019 pages, illustrated. 8vo. Cloth, $10.00.

PLASTIC SURGERY. By Arthur J. Barsky, M.D., D.D.S. Philadelphia, W. B. Saunders Company, [c. 1938]. 355 pages, illustrated. 8vo. Cloth, $5.75.

THE PNEUMONIAS. By Hobart A. Reimann, M.D. Philadelphia, W. B. Saunders Company, [c. 1938]. 381 pages, illustrated. 8vo. Cloth, $5.50.

ESSENTIALS OF PATHOLOGY. By Lawrence W. Smith, M.D. and Edwin S. Gault, M.D. New York, D. Appleton-Century Company, [c. 1938]. 886 pages, illustrated. 4to. Cloth, $9.00.

DISEASES OF THE EYE. By Sir John H. Parsons, F.R.C.S. Ninth edition. New York, The Macmillan Company, [c. 1938]. 705 pages, illustrated. 8vo. Cloth, $5.50.

VIRUS DISEASES AND VIRUSES. By Sir Patrick P. Laidlaw, M.A. New York, Macmillan Company (Cambridge University Press), [c. 1938]. 52 pages. 12mo. Cloth, $.90.

You may obtain any of the books reviewed in this department by sending your remittance of the published price to Book Department of the MEDICAL TIMES, 95 Nassau Street, New York, N. Y.

STATE MEDICAL SOCIETIES

State medical societies should be the real executive branch of organized medicine. From them should come a major part of the opposition to the various encroachments upon medical practice and likewise they should materially assist in devising plans for the better distribution of medical services. State medical societies which fail to energetically carry on these two functions, contenting themselves with the election of inactive or inefficient officers, confining their work very largely to the few days of the annual meeting, and offering no definite leadership or taking no definite stand on the vital issues facing the medical profession, are failing in their duty both to the profession and the public.—M. D. Hargrove, M. D. In *Tri-State Medical Journal*, June, 1938.

SOCIAL INSURANCE

The treatment of the sick is essentially a personal service. It cannot be organized on a large scale. Any attempt to do so must disregard and thereby destroy the intangible values which play such a large and important part in successful medical care.—Editorial. In *New York Medical Week*, April, 1938.